Board of County Commissioners
Leon County, FL

Workshop on
County Employee Health Insurance Options

1:30 – 3:00p.m.
Tuesday, February 22, 2005

Leon County Courthouse
Commission Chambers
5th Floor

Distributed on February 16, 2005

Board of County Commissioners
Workshop Agenda

Date of Meeting:	February 22, 2005
Date Submitted:	February 16, 2005
To:	Honorable Chairman and Members of the Board
From:	Parwez Alam, County Administrator PA Lillian Bennett, Human Resources Director LWB
Subject:	Board Workshop on County Employee Health Insurance Options

Statement of Issue:

At the request of the Board, this workshop is scheduled to discuss County Employee Health Insurance options; present the results of an Employee Health Insurance Survey (Attachment #1); and request Board approval to issue a Request for Proposals (RFP) for County Employee Health Insurance (Attachment #2). Staff is also seeking Board approval to negotiate an agreement under State Contract #973-500-03-1, with a recognized health benefits consultant, to provide consulting services in the review, analysis and evaluation of the County's current health plan, draft RFP and health plan proposals (Attachment #3).

Background:

At the September 14 and 21, 2004 meetings, the Board approved the annual renewal of health insurance coverage for the 2005 plan year with Capital Health Plan (CHP) and Vista (Attachment #4). United Health Care (United), a national health care insurer, new in the Leon County service area, submitted a request to be considered as a third provider of health insurance coverage for Leon County, in addition to CHP and Vista.

The Board approved staff recommendation to continue with CHP and Vista for the 2005 plan year and to schedule a Board workshop in early 2005 to discuss employee health insurance options prior to the 2006 renewal period. In addition, at the 2005 Board retreat, the Board discussed employee health insurance and requested the Chairman to invite the City of Tallahassee and the Leon County School Board to participate in a group health insurance program with Leon County.

As requested by the Board, the Chairman submitted a request to the City of Tallahassee and the Leon County School Board to determine their interest in participating in a group health insurance program (Attachment #5). On January 2005, a response was received from the Leon County School Board indicating a willingness to discuss the issue (Attachment #6). In addition, as a result of discussions between the Chairman and the Mayor at the January 2005 Mayor/Chair meeting, staff was instructed to develop a staff committee consisting of County, City and School Board representatives to look into the feasibility of establishing an Employee Group Health Insurance Consortium.

Analysis:

Leon County currently contracts with CHP and Vista (formerly Health Plan Southeast) for the provision of medical services for its employees. Both CHP and Vista currently provide Health Maintenance Organization (HMO) benefit plans. A history of CHP and Vista is shown in Attachment #7. United is a new provider in the Leon County service area; however, they are a national leader in the consumer health services market. United provides an array of services and is very interested in becoming a health insurance provider in Leon County. A history of United is shown in Attachment #8.

This workshop will address the following issues related to County Employee Health Insurance:

- Results of Health Insurance Survey
- Analysis of Physician and Hospital Network
- Five-Year History of County Medical Costs
- Request for Proposals and Insurance Options
    - Fully Insured HMO Option
    - Fully Insured POS Option
    - Fully Inured PPO Option
- Feasibility of Group Health Insurance Consortium (County, City and School Board)
- Opt-Out/Spouse Program Proposal

Health Insurance Survey Results

During open enrollment, in November 2004, Leon County Human Resources conducted a County Health Insurance Survey. The purpose of the survey was to gather input from employees on the quality, accessibility and cost of current health insurance services. The participants in the survey included employees from the Board and Constitutional Offices. A total of six hundred sixty-six (666) employees completed the survey from a total enrollment of 1,414 or approximately 47%. Generally, County employees are very satisfied with the quality of service, accessibility and cost of services provided by CHP and Vista. Employees would like to remain with their present physician network and would prefer an increase in cost over a change in medical providers. The complete results of the health insurance survey are shown in Attachment #1.

While County employees are generally satisfied with the current services, it should be noted that employees are currently only responsible for 7.5% of the total cost of their health insurance. Under family coverage, this equates to about $78 per month/per employee. Leon County pays the remaining 92.5%. Under family coverage, Leon County pays more than $1,000 per month/per employee. As a result, employees have not been significantly impacted by the double-digit increases Leon County has experienced in the cost of medical services. In the recent health insurance survey, when employees were asked the top two things they liked most about their current insurance services, the response was "low cost" and "everything".

Physician and Hospital Network Analysis

In order to determine the potential impact of any future decision that may be made by the Board in regards to the selection of a new insurance carrier, staff has performed a preliminary analysis of the current primary care physician and hospital provider network for CHP, VISTA and United. The analysis includes a breakdown of the number of primary care physicians available at each insurance carrier (Table #1) and the number of employees and dependents impacted (Table #2).

As reflected in Table #1 below, CHP has a total of 112 primary care physicians. Of that amount, a total of thirty-three (33) physicians are staff model physicians; (25) employed by CHP at their Centerville Road or Governor's Square locations or are independent private physicians (8) that are exclusive to the CHP network. This represents approximately 30% of the total CHP primary care network. The remaining 70% of physicians in the CHP network are also available in either the Vista or United networks.

Vista has a total of 105 primary care physicians. Of that amount, a total of twenty-five (25) physicians are available only in the Vista network. This represents approximately 24% of the Vista primary care network. The remaining physicians in the Vista Network, approximately 76%, are also available in the CHP or United network.

United Health Care has a total of seventy-seven (77) primary care physicians in its newly established Leon County network. Approximately thirty-nine (39) or 51% of these physicians are currently going through the credentialing process. The remaining 42% of physicians are also available in the CHP or Vista network. United currently has an agreement for services with Tallahassee Memorial Hospital, however, at present, United has not finalized an agreement with Capital Regional Medical Center. United is continuing to develop its network within the Leon County service area.

Table #1
Physician Network Analysis

# Physicians participating in each Network	Capital Health Plan		Vista		United Health Care	
Total Primary Care Physicians	*112*		*105*		*77*	
CHP staff model physicians in CHP network only and Independent Physicians in CHP network only	33	30%	0	0%	0	0%
Independent Physicians in CHP and Vista network	50	45%	50	48%	0	0%
Independent Physicians in CHP, Vista and United networks	26	23%	26	25%	26	34%
Independent Physicians in CHP and United network only	3	2%	0	0%	3	4%
Independent Physicians Vista and United network only	0	0%	4	4%	4	5%
Independent Physicians in Vista network only	0	0%	25	24%	0	0%
Independent Physicians in United network only	0	0%	0	0%	5	6%
Physicians undergoing credentialing in United network	0	0%	0	0%	39	51%
Local Hospital Network (TMH and Capital Regional)	2		2		1 (TMH Only)	

Table #2 below provides an impact analysis of the number of employees/dependents required to select new primary care physicians if the County made a change in health plan providers. Approximately 85%, of Leon County's employees, both Board and Constitutional, are enrolled with CHP. If the County made a major change from CHP to a new health plan provider, a total of 1,630 employees and their dependents, or approximately 51% of the total CHP enrollment would be impacted. These employees are currently enrolled with CHP staff model physicians or independent physicians exclusive to the CHP network. As such, these employees would be required to select new primary care physicians. Approximately 49% of remaining employees in the CHP network can remain with physicians that are also available in either the Vista or United networks. A change from CHP as a health plan provider would create a significant employee impact.

If a change were made from Vista to a new health plan provider, a total of 48 employees and their dependents would be impacted. These employees are currently enrolled with physicians exclusive to the Vista network. These employees represent approximately 9% of the total County enrollment in Vista. Approximately 91% of employees in the Vista network should be able to remain with physicians that are also available in either the CHP or United networks. A change from Vista as a health plan provider would not create a significant employee impact.

Table #2
Employee/Dependent Impact Analysis
(Includes employees, retirees and COBRA participants)

	Capital Health Plan				Vista			
# Employees/Dependents Impacted by Potential Change in Provider	# of Employees Impacted	# of Dependents Impacted	Total Members Impacted	%	# of Employees Impacted	# of Dependents Impacted	Total Members Impacted	%
CHP staff model and independent physicians in CHP network only	782	848	1630	51%	0	0	0	0%
Independent Physicians in CHP and United networks	34	33	67	2%	0	0	0	0%
Independent Physicians in CHP and Vista networks	406	610	1016	31%	113	194	307	56%
Independent Physicians in Vista and United networks	0	0	0	0%	27	19	46	8%
Independent Physicians in CHP, Vista and United networks	203	295	498	16%	81	67	148	27%
Independent Physicians in Vista network only	0	0	0	0%	28	20	48	9%
Total Employee /Dependents Impacted	1425	1786	3211		249	300	549	

If any decision to change insurance providers is made, staff will need to move very quickly in planning for the change in the administration of the County's health insurance plan and conduct employee information sessions to notify employees of the impact of potential changes in physician network.

Five Year History of Medical Costs

Throughout the country, health care costs are continuing to rise at double digit rates. Leon County is no exception. Over the past five (5) years, Leon County's health insurance rates have increased annually an average of 15% for CHP and 17% for Vista, as shown in Table #3 as follows:

Table #3

Five (5) Year History of Premium Rates for CHP and Vista

Year/Company	Employee	Employee + 1	Family	Rate Increase Percentage
Year 2000				
CHP	$197.70	$409.20	$523.90	
VISTA	$185.19	$378.71	$508.71	
Year 2001				
CHP	$222.80	$461.10	$590.30	13%
VISTA	$199.94	$408.87	$549.23	8%
Year 2002				
CHP	$256.60	$531.10	$679.90	15%
VISTA	$238.92	$488.59	$656.31	19%
Year 2003				
CHP	$300.10	$621.20	$795.30	17%
VISTA	$291.71	$603.78	$772.92	22%
Year 2004				
CHP	$342.00	$708.00	$906.40	14%
VISTA	$367.96	$761.61	$974.96	26%
Year 2005				
CHP	$392.50	$812.50	$1,040.20	15%
VISTA	$407.64	$843.74	$1,080.10	11%

In terms of actual dollars, County medical cost has risen from a total of $6.2 million in FY 1999 to an estimated $13.6 million in FY 2005. This represents an increase of more than $7.4 million over a six year period, or approximately 119%. Table #4 provides a summary of the total dollar cost of health insurance over the past six years:

Table #4

Leon County Actual Health Insurance Cost (FY 1999 – 2005)

(Includes Employees, Retirees and Cobra Participants)

Fiscal year	CHP	% Increase	Vista	% Increase	Total	Total % Increase
1999	$4,632,663		$1,571,075		$6,203,738	
2000 *	$5,269,542	14%	$1,303,316	(17%)	$6,572,858	6%
2001*	$6,220,952	18%	$1,245,508	(4%)	$7,466,461	14%
2002	$7,158,011	15%	$1,419,366	14%	$8,577,378	15%
2003	$8,302,887	16%	$1,543,216	9%	$9,846,103	15%
2004**	$10,003,520	20%	$1,814,078	18%	$11,817,598	20%
2005***	$11665,822	17%	$1,929,720	6%	$13,595,542	15%
Total Dollar & % increase since 1999	$7,033,159	152%	$358,645	23%	$7,391,804	119%

* 2000 and 2001 reflected a significant decrease in enrollment for Vista

**2004 establishment of EMS Division increased enrollment

*** 2005 is an estimate of the health insurance cost based on January 2005 enrollment numbers.

Locally, government agencies have experienced similar health care cost trends. Increases in premiums have ranged from 10% to 19% since year 2000. Attachment #9 shows a comparison of the State of Florida, City of Tallahassee and Leon County School Board monthly premium amounts from 2000- 2004. Increases in premium rates for retirees for family coverage, when both spouses have Medicare, have ranged from 3% to 20% for CHP. A summary of rates for retirees is also shown in Attachment # 9.

Request for Proposals

Due to limited competition within the local market area, historically, Leon County has entered into informal negotiations with two health care providers, CHP and Vista. This has resulted in minimal competition and double-digit increases during the annual renewal process. With the increased possibility of competition and the arrival of United Health Care into the local service area, staff is requesting Board approval to enter into a competitive bid process (RFP) for the County's health insurance. Section 112.08, Florida Statues - "Group insurance for public officers, employees, and certain volunteers; physical examinations" states that ".....Before entering any contract for insurance, the local governmental unit shall advertise for competitive bids; and such contract shall be let upon the basis of such bids" (Attachment #10). Accordingly, a draft RFP for Health Insurance Services is included as Attachment #2.

The RFP requests proposals on the following insurance plan options:

- Fully Insured Health Maintenance Organization (HMO)
- Fully Insured Point of Service Plan (POS)
- Fully Insured Preferred Provider Organization (PPO)

Through the RFP, respondents will be asked to respond to one or more of the insurance plan options noted above or a combination of plans, such as an HMO/PPO dual option. Respondents will also be asked to respond as a single provider of health services and as one of two providers of health services for Leon County. Staff will also request multi-year rate guarantees and performance standards and guarantees for each proposal as well as periodic reporting requirements. A summary and comparison of the differences between the fully insured managed care plans (HMO, POS and PPO) is included in Attachment #11.

Staff request Board approval to issue the RFP for Health insurance and to negotiate an agreement with a health benefits consultant under State Contract #973-500-03-01 (Benefits Consulting Services and Actuarial Services) in an amount not to exceed $40,000. The authorized consultants under State Contract are Mercer Human Resource Consulting, Milliman, Inc. and Palmer and Cay Consulting of FL. The proposed consultant will analyze the County's current health benefits, help develop and assess alternative plan designs, compare and contrast these with plans available in the Leon County community and recommend the best benefits plan for Leon County. The consultant will also review the draft RFP and provide an evaluation of the RFP proposals submitted and present recommendations for a health insurance provider.

Other options the Board may consider in future years is to consider the feasibility a Self-Insurance Health Plan and Health Savings Accounts with a High Deductible Health Plan. A staff summary on Self-Funding and Health Savings Accounts and an article which further explains self funding of employee health benefits is included as Attachment #12.

In accordance with Florida Statutes 1112.08, several Florida counties have issued RFP's for health insurance coverage. In addition, several counties have elected to self-insure their health plans including Brevard, Manatee, Pinellas, Sarasota, St. Johns, St. Lucie and Volusia Counties (Attachment #13). The State of Florida is currently reviewing the possibility of HSA's in the 2005 Legislative Appropriations Bill (Attachment #14). The bill does propose that the State match the employee HSA contribution up to a maximum of $1,000.

Feasibility of Group Health Insurance Consortium

As directed by the Board, on February 11, 2005, staff met with staff from the City of Tallahassee and the Leon County School Board to discuss the feasibility of establishing a Group Health Insurance Consortium. The City of Tallahassee currently contracts with CHP as their sole insurance provider and offers employees an HM0/PPO dual option. In addition, the City of Tallahassee maintains an on-going agreement with a consultant to thoroughly review their health insurance plan design, make recommendations for improvement and assist in the annual negotiations of renewal rates. The Leon County School Board currently contracts with CHP and Vista for health insurance. Similar to Leon County, the School Board only offers an HMO option to its employees. Unlike Leon County, the City and the School Board have shifted more of the costs for health insurance to their employees. Currently, the School Board is participating in a feasibility study with the Panhandle Area Educational Consortium (P.A.E.C) to make recommendations on what strategies it can take to improve its health insurance plan. The results of this study are to be completed in April 2005.

Both the City and the School Board staff have been asked by Leon County staff to consider participation in the RFP process with Leon County. Both entities will discuss the matter with their respective Administrators and notify Leon County prior to the workshop on February 22, 2005. Should the City or the School Board express a desire to participate, staff request a delay in the issuance of the RFP to allow each entity an opportunity to review the RFP, provide input and provide data required in the RFP relative to their respective agencies. If the City and School Board decide not to participate in the RFP, staff request Board approval to move forward in the issuance of the draft RFP in accordance with Florida Statutes 112.08. In the short term, if any decision is made to change insurance providers, staff will need to move quickly in planning for the new administration of health insurance plan and notifying employees of potential changes in physician network. In the long term, if the School Board and City express an interest, staff can still continue to meet with City and School Board representatives to determine the feasibility of a Group Health Consortium and what future steps should be taken.

Opt-Out/Spouse Program Proposal

Leon County currently provides an Opt-out Program for employees. Essentially, the Opt-out program allows those employees who provide proof of medical insurance outside of Leon County government (ex. Board, Clerk, Sheriff, Tax Collector, Property Appraiser or Supervisor of Elections) the opportunity to receive a payment of $300 per month or $3600 annually in lieu of participating in the County's medical plan. Historically, this has resulted in significant savings to the County, since the County pays for 92.5% of employee medical coverage.

For example, under a CHP family coverage plan, the net savings to the County of an employee electing to opt-out of participation in the County's medical plan, amounts to approximately $7,946 annually per employee ($11,546 (County Cost) - $3,600 (Opt-out) = $7,946 County net savings). Accordingly, the Opt-out payment has not been provided to spouses who both work for Leon County government, since both employees are active participants in the County's medical plan. The County assumes all the liability, risk, medical claims experience and rate increases associated with these employees since one of the spouses is listed as a dependent under the County's medical plan.

Attached is a February 14, 2005, letter from the Clerk of Courts regarding additional health care benefits to employees when either spouse work for the same or separate Board or Constitutional Office (Attachment #15). The Clerk is requesting Board consideration of two proposals related to spousal employee medical insurance payments and staff presents a third as follows:

a. Provide an additional opt-out benefit of $300 per month or $3600 per year to employees where both spouses work for the Board or any Constitutional Office. Currently, these employees are not eligible for opt-out since both spouses are fully covered under the County's medical insurance plan. The County assumes all the liability, risk, medical claims experience and rate increases associated with each employee. In reviewing the practices of the City, School Board and State of Florida in this area, staff determined that the City provides a total of $25 a month or $300 annually for opt-out for one spouse when both are employees through their flexible benefits program. The City provides this benefit without regard to whether or not the spouses has coverage from the City or another public/private employer. The School Board and the State of Florida do not currently provide opt-out to their employees. Staff does not support this proposal and request Board approval to maintain the original intent and cost savings associated with the opt-out program by requiring employees to provide proof of insurance coverage outside of Leon County Board or Constitutional Office.

b. Provide full payment of medical insurance costs when both spouses work for any Board or Constitutional Office. For Board employees, the County currently pays 100% of the cost for medical insurance for married couples that are both employed under the Board. However, some Constitutional Offices are not currently providing this benefit to their employees. In addition, employees whose spouses both work for separate Leon County government agencies are not provided the full benefit of payment of all medical insurance costs. Staff supports this proposal and recommends that all of the Constitutional Offices provide full payment of medical insurance to employees when both spouses are employed with Leon County. Staff will work with the Clerk's Office to develop procedures for the implementation of this proposal.

c. Equally distribute between agencies, the total medical insurance costs of employees when both spouses work for any separate Leon County Board or Constitutional Office (ex. Clerk and Board). Staff supports this proposal and the Clerks Office can administer the process for the equitable distribution of cost among Leon County agencies since it currently coordinates medical insurance payments with the Constitutional Offices.

Options:

1. Direct staff to issue Request for Proposal on County Employee Health Insurance to include proposals on the following :
    a. Fully Insured HMO Plan
    b. Fully Insured POS Plan
    c. Fully Insured PPO Plan.

2. Direct staff to negotiate an agreement under State Contact #973-500-03-01, Benefits Consulting and Actuarial Services with one of the three vendors listed under the State Contract to provide health benefits consulting in an amount not to exceed $40,000 from general fund contingency and authorize the chairman to execute.

3. Contingent upon the pending response from the City and the School Board, approve participation of the City and the School Board in the RFP for Health Insurance Services.

4. Approve one or more of the following Opt-Out/Spouse Program for Board and Constitutional Offices.

    a. Provide an additional Opt Out Benefit of $300 per month or $3,600 annually to employees where both spouses work for any Board or Constitutional Office
    b. Provide full payment of medical insurance cost when both spouses work for any Board or Constitutional Office
    c. Equally distribute between agencies the total medical insurance cost of employees when both spouses work for any separate Board or Constitutional Office

5. Board Direction

Recommendation:
Options #1, #2, #3, #4b and #4c.

Attachments:
1. County Employee Health Insurance Survey
2. Draft RFP for County Health Insurance
3. State of Florida Contract for Consulting Services
4. September 21, 2004 Agenda Item on 2005 Renewal
5. Letter to City of Tallahassee and Leon County School Board dated January 5, 2005
6. Letter from Leon County School Board dated January 19, 2005
7. History of CHP and Vista
8. History of United Health Care
9. Comparison of Premium Rates-County, State, City and School Board
10. Copy of Florida Statutes 112.08
11. Summary and Comparison of Fully Insured HMO, POS and PPO Plans
12. Article by Performax on Self-Funding Employee Health Benefits
13. County Comparisons RFP's issued and Self-Insured Health Plans
14. State of Florida Legislative Bill on HSA's
15. Opt-Out/Spouse proposal from Clerk's Office

HEALTH INSURANCE EMPLOYEE SURVEY REPORT

Report of Survey conducted by LCBCC Human Resources Office in November 2004

Board of County Commissioners

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Introduction

Each year, Leon County government reviews the health insurance (and other benefits) it offers employees to ensure that it is offering the most relevant benefits for the most economical costs. Currently, Leon County offers health insurance via two health maintenance organizations (HMOs), Capital Health Plan (CHP) and VISTA. Both require that patients see specific physicians, hospitals, and other providers that contract with the HMO. Capital Health Plan provides services through both CHP-employed physicians in its own centers and a network of private physicians. VISTA offers services through a private physicians' network only. In Fiscal Year 2004, 1,203 Leon County employees enrolled in Capital Health Plan and 211 enrolled in VISTA (Table 1). The County is exploring other health insurance options and will circulate a request for proposals to select health insurance providers for Fiscal Year 2006 and beyond.

Table 1: County Health Insurance Enrollment, FY 2004

County Entities	CHP		VISTA	
Clerk's Office	108	8%	26	2%
Tax Collector' Office	62	4%	17	1%
Property Appraiser's Office	36	3%	7	0%
Sheriff's Office	473	33%	66	5%
Board of County Commissioners plus Supervisor of Elections	524	37%	95	7%
TOTALS	**1203**	**85%**	**211**	**15%**

This report describes the results of the LCBCC Health Insurance Survey 2004 (Appendix 1) that was conducted to determine how satisfied employees are with the current health insurance plans and what they would like included in future plans. The survey was conducted in November 2004. It was available to all County employees both in hard copy and online. Copies were circulated at the November 2004 Benefits Fairs and in various County work units. Also, a link to the online form of the survey was e-mailed to all employees in the County e-mail system. Employees were given a month to respond to the survey. Six hundred sixty-six employees completed the survey (Table 2). They were members of the following County entities:

Table 2: Respondents by County Entity

County Entity	# Responding	% Responding
Board	387	58%
Clerk	60	9%
Property Appraiser	3	0%
Sheriff's Office	191	29%
Supervisor of Elections	12	2%
Tax Collector	13	2%
TOTAL	666	100%

Eighty-three percent of the respondents were with Capital Health Plan and 15% were served by VISTA. The typical respondent was a CHP member between 35 and 54 years of age who had been employed with Leon County for at least 5 years, had family health coverage and had been with his or her physician for at least six years.

Executive Summary

The LCBCC Health Insurance Survey 2004 determined how satisfied employees were with the current health insurance plans and what their preferences are for future plans. The results from the 666 respondents indicated that most employees were satisfied with their current health insurance. Overall 65% were very satisfied with the group of doctors available. Both Capital Health Plan and VISTA employees showed high levels of satisfaction. When asked if they would change physicians if a plan with similar costs was offered, 74% of the employees said "no." Also, 61% indicated that they would not change plans even if the costs were less. The unwillingness to change physicians was consistent regardless of age, years with current physician or years with the County.

Thirty-three percent of the employees preferred to have a PPO compared to 66% who wanted an HMO. Employees were about equally split on whether they thought the County should have one provider that offers both an HMO and a PPO.

Employees would prefer to increase the cost of office visits and therapy rather than prescriptions or diagnostic tests. Also, they would rather increase the cost of co-pays than to increase premiums.

When asked what they liked about their health insurance, the top two items were *cost* and *everything*. When asked about dislikes of their health insurance, the top items were *high/varying copays*, *other costs (premiums, etc.)* and *having to get referrals*.

Respondents offered a long list of questions to ask potential future insurers. They covered a wide range of topics; ones with several questions included:

- costs
- coverage
- customer service
- doctor network
- patient choice
- referral system
- reimbursements

The results of the survey will be used in designing the request for proposals to select the insurer(s) for Fiscal Year 2006. Also, the information will inform Human Resources staff as they plan for further informing employees about County health insurance plans.

Survey Sample

The distribution in the survey sample is highly representative of the distribution of employees in the Leon County health plans. Eighty-three percent (553) of the respondents are served by Capital Health Plan (Table 3). This compares to 85% of the total employee population that is served by this plan. Of the 83% CHP respondents, 39% are served at a Capital Health Plan center. Fifteen percent of the respondents are served by VISTA as compared to the 15 % of employees served by VISTA throughout the County.

Table 3: Respondents by Type of Service

	#	%
CHP Doctor at Centerville Rd or Gov Sq CHP office	261	39%
CHP Private Practice Physician	292	44%
VISTA Private Practice Physician	97	15%
Optout	1	0%
Did not answer	15	2%
	666	

Regardless of years of service, more respondents were with CHP (Table 4). Overall, a few more respondents were seen by CHP private physicians than at CHP centers.

Table 4: Type of Service by Years with the County

YRS WITH COUNTY	CHP		CHP PRIVATE		TOTAL CHP		VISTA		TOTAL
<6 months	8	33%	14	58%	22	92%	2	8%	24
6 m - 1 yr	25	34%	40	54%	65	88%	9	12%	74
2-5 yr	64	44%	58	40%	122	85%	22	15%	144
6-10 yr	56	48%	49	42%	105	91%	11	9%	116
11-15 yr	43	37%	53	45%	96	82%	21	18%	117
>15 yr	59	36%	73	45%	132	81%	30	19%	162

In all agencies, except the Supervisor of Elections Office, more respondents were with Capital Health Plan.

Employee Satisfaction and Dissatisfaction with Current Health Insurance

Satisfaction with the Primary Care Physician

Overall, respondents have been with their current primary care physician for six or more years (Table 5). In fact, for both CHP and VISTA, about 40% had been with the current doctor for more than 10 years.

Table 5: Years with Current Physician

0-1 yrs	70	11%
2-5 yrs	181	27%
6-10 yrs	144	22%
>10 yrs	265	40%
TOTAL	660	

Sixty-five percent were satisfied with the group of doctors available under their current plan (Table 6). CHP respondents were 69% very satisfied while VISTA ones were 55% very satisfied (Table 7). Overall, only 3% or respondents were not at least somewhat satisfied. The majority of respondents of all age groups and from all County entities were somewhat or very satisfied.

Table 6: Overall Satisfaction with Physicians

Very satisfied	435	65%
Somewhat satisfied	201	30%
Not satisfied	20	3%
Did not answer	10	2%
TOTAL	666	

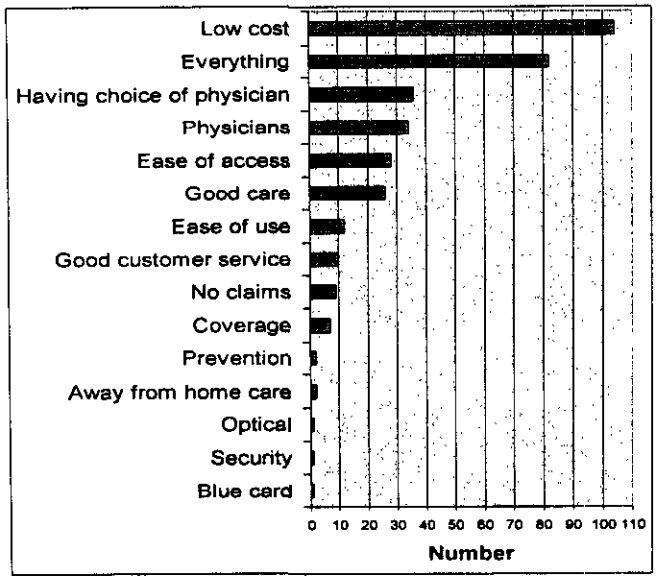
Table 7: Physician Satisfaction by Insurance Type

		CHP Center		CHP Private Physicians		TOTAL CHP		VISTA	
Very satisfied		189	73%	188	64%	377	69%	54	57%
Somewhat satisfied		66	26%	99	34%	165	30%	36	25%
Not satisfied		3	1%	5	2%	8	1%	9	1%

What Employees Like About Their Current Plans

Overall, employees liked many aspects of their current plans (Chart 1). Fifty-two percent listed *low cost* and *everything* as their top "likes."

Chart 1: What Employees Like About Current Health Plans



These two were the top selections for the Board, Sheriff's and Clerk's offices. The same ones were selected by both CHP and VISTA respondents. CHP respondents listed *satisfaction with*

their physicians as #3 and VISTA respondents listed *having a choice of physicians* as #3. Here is a sample of the actual comments made about "likes."

- The cost is right.
- I love the premiums that we pay each month. I also enjoy the low cost of co-pays, prescriptions, and lab work.
- The copays are not too high and member premiums are payroll deductible.
- VISTA is the best insurance in Leon County. The particular plan that Leon County enrolled us in was the true Cadillac" of local health care coverage. The physicians treat you like royalty when you walk in the door. No wait. I am also very satisfied with the doctors available under my plan.
- I have had CHP for 6 years now and they have never denied a claim, are thorough and expeditious. Their Acute Care Center is a wonderful alternative to an ER.
- My primary doctor is great
- Like my doctor and feel he keeps up with my health issues to help me stay well.
- I like that the relationship with my primary care physician is very close and personal. She knows me well and I trust her implicitly.
- I like that you get to choose your doctor, and also you get to know your doctor as he or she gets to know you. There is no guess work about your health because the doctor has your record.

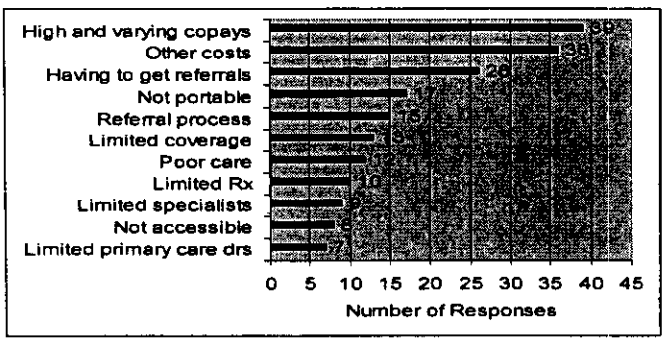
What Employees Dislike About Their Current Plans

Overall, the top "dislikes" were *high and varying copays*, *other high costs* and *having to get referrals* (Chart 2). These "dislikes" were gleaned from a variety of comments; here is a sample:

- Premiums go up every year just after we get our cost of living raise. It usually takes our whole raise.
- The fact that my cost will skyrocket when I retire. That is just the time when you need to pay less.
- I do not like the fact that premiums are increasing.
- It is very expensive.
- Copays going up and the amount for a visit to the Emergency Room.
- Price going up
- The 3 tiered prescription coverage. Almost all drugs that are prescribed seem to end up on the top (most expensive) tier.
- having to go through my primary physician to see a specialist or ob/gyn
- The wait for referrals
- The reluctance of the primary physician to send you to a specialist

High copays and *other costs* were listed among the top three dislikes by the Board, Clerk's Office and Sheriff's Office. The Board organization also listed *not portable* among its top three dislikes. The Sheriff's Office included *having to get referrals* in its top three. Employees who had physicians at CHP centers disliked *high copays* and *other costs*. Those who saw CHP private care physicians disliked *high copays*, *having to get referrals* and the *limited number of primary care physicians*. Employees covered by VISTA disliked that their insurance was *not portable*.

Chart 2: What Employees Dislike about Current Health Plans



Employee Preferences for Future Health Insurance

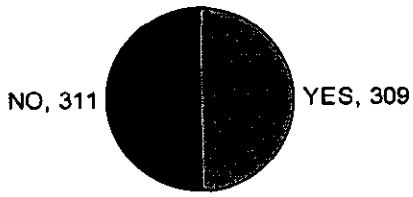
HMO or PPO?
Sixty-six percent of respondents preferred an HMO. Thirty-three percent preferred a PPO.

Table 8: HMO or PPO?

HMO	437	66%
PPO	220	33%
No response	9	1%

The respondents were split (46% yes to 47% no) on their response to whether one company should provide both the HMO and PPO options.

Chart 3: Should One Company Offer Both HMO and PPO Options?



Employees Did Not Want to Change Physicians
Respondents did not want to change physicians for similar coverage or reduced costs. (Table 9, Table 10, Charts 3-5). Regardless of how long the employee had been with the physician or the age of the employee, the decision was not to change even if the cost was less.

Table 9: Change Physician for Plan With Similar Costs/Coverage

Yes	155	23%
No	490	74%
No response	21	3%

Table10: Change Physician for Plan With Less Cost

Yes	250	38%
No	403	61%
No answer	10	2%

Chart 3:
Change Physician /Similar Costs &Coverage, by Years with Physician

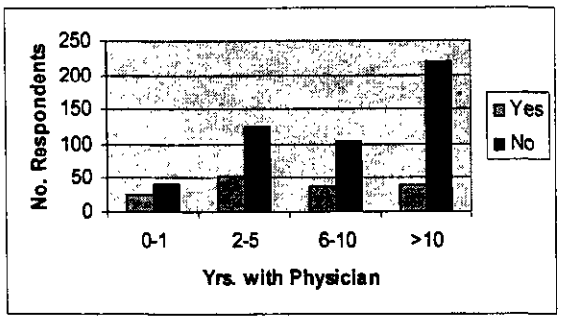


Chart 4:
Change Physician /Similar Costs &Coverage, by Years with Physician

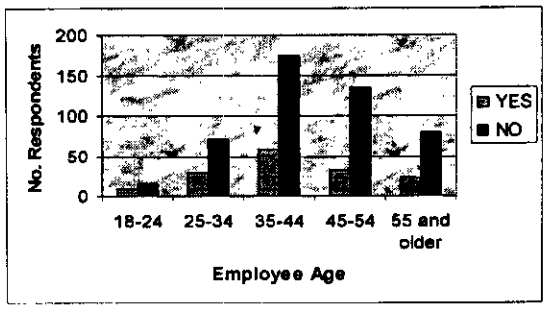
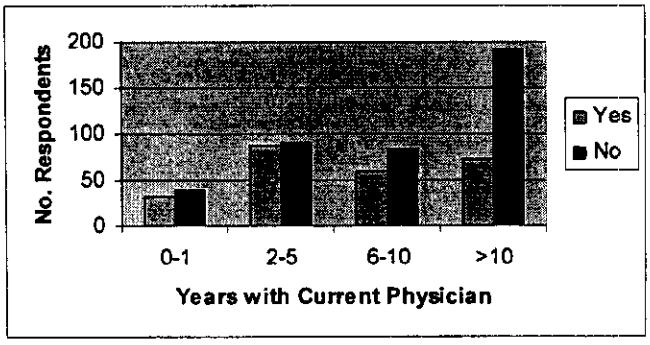


Chart 5:
Change Physician for Plan
With Less Cost



Higher Premiums or Higher Copays?
Employees were asked to indicate whether they would prefer higher premiums or higher copays. Fifty-five percent preferred higher copays. This finding was constant regardless of level of coverage or age of employee. Employees who had been employed 0-5 years and 11-15+ years also preferred higher copays instead of higher premiums. The "6-10 years with County" group was split (60- higher premiums; 58-higher copays).

Questions to Ask About Future Plans

Employees provided a very long list of questions to ask in obtaining future health insurance plans. The questions were grouped into the following categories:

- Access
- After hour care
- Alternative therapies
- Cost vs coverage
- Costs of co-pays/ premiums/prescriptions
- Coverage
- Customer service
- Deductibles
- Doctor network
- Doctor quality
- Doctor timeliness
- Doctor vs Insurance decision
- Drugs availability
- Extended care
- Hospital availability
- Lawsuits
- Local company
- Local lab availability
- Massage therapy
- Mental health
- More RX, lower co-pay
- New offers
- Non-profit status
- One stop service
- Outside area coverage
- Paperwork
- Patient choice
- Pharmacy availability
- Pre-existing conditions
- Prevention
- Referral system
- Reimbursement
- Retiree costs/choices
- Specialists

Following is a sample of the questions the employees provided:

- How many patients per doctor. ratio?
- What about after hour care?

- What type of coverage do they have for alternative forms of medical treatment such as chiropractic, massage therapy, acupuncture, physical therapy, etc?
- Can premiums be lower if certain coverages are eliminated from your plan (i.e. obstetrics, alcohol or drug treatment)?
- How to keep the cost of prescriptions affordable? How to keep the cost of insurance affordable?
- Is there a way to increase one time service expenses to reduce future increases to the monthly premium?
- Are there any economies of scale savings by making negotiations concurrently with other government entities to pass those savings to our employer, Leon County?
- Establish a sliding scale that would increase copays for various things after reaching a certain level to deter abuse of the system and causing the cost to rise for those of us that do not abuse it for every little ache and pain.
- What, if any, hidden fees could be charged to the patient?
- Why charge more for walk-in visits than appointments?
- Add cosmetic procedures to benefits.
- Provide a list of definite coverages to its customers for certain various treatments in advance.
- What is their customer service philosophy? How do they handle grievances and complaints?
- How many doctors and what types of care or services are provided by each?
- Will the current doctors be available for employees? Are we limited to area doctors for special concerns?
- What drugs are covered?
- Are they connected with both hospitals?
- Do you have a Nurse Line or similar service?
- Do you have discounts for multi-month prescription purchases?
- Is there coverage outside of immediate area?
- Are specialist providers local or do you only get treatment at a facility not located locally?
- What preventative programs do they offer?
- How user friendly is the referral process, steps for reconsideration if disapproved?
- Can the retirees keep group plan even though they relocate outside the CHP 5 county radius? Is there any way to reduce premiums for those who do not abuse available services?
- Does your PPO plan have a large network of specialty Doctor's and will you maintain this relationship?

REQUEST FOR PROPOSALS

for

EMPLOYEE MEDICAL COVERAGE

Proposal Number BC-00-00-05-00

BOARD OF COUNTY COMMISSIONERS

LEON COUNTY, FLORIDA

Release Date:

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
Opening Date:

I. INTRODUCTION

A. Leon County is seeking fully insured quotes for employee medical coverage. Leon County is requesting vendors to propose on a:
1. Fully Insured HMO
2. Fully Insured PPO
3. Fully Insured POS Plan

Leon County reserves the right to reject any/or all proposals and to make awards as they may appear to be advantageous to the County; to hold proposals for 60 days from the submission date without action, and to waive all formalities in proposal process. Your proposal may include any or all of the following:

Submissions should include quotes which assume both:
-That your company will be our only medical plan provider and
-That your company will be one of two medical plan providers

ALL SUBMISSIONS WILL BE COMPARED TO THE CURRENT MEDICAL PLANS AS A BASELINE FOR QUALITY AND COST.

IF DEVIATIONS ARE MADE FROM THE CURRENT PLAN, PLEASE EXPLAIN THE DIFFERENCES.

B. Coverage shall be effective January 1, 2006 or on a later date requested, in writing, to the bidder by the County. Coverage shall be guaranteed for a minimum of 12 months from the effective date at the same premium rate quoted in the bid. It is the County's intent to renew the coverage after the initial coverage period by negotiation with the bidder. Such renewal process may be conducted annually. The County must be notified 90 days in advance of the contract anniversary date of any premium increases.

II. GENERAL INSTRUCTIONS:

A. The response to the proposal should be submitted in a sealed addressed envelope to:

Proposal Number: BC-00-00-05-00
Purchasing Division
2284 Miccosukee Road
Tallahassee, FL 32308

B. An ORIGINAL and nine (9) copies of the Response must be furnished on or before the deadline. Responses will be retained as property of the County. **The ORIGINAL of your reply must be clearly marked "Original" on its face and must contain an original, manual signature of an authorized representative of the responding firm or individual,** all other copies may be photocopies.

C. Any questions concerning the request for proposal process, required submittals, evaluation criteria, proposal schedule, and selection process should be directed to Keith Roberts or Don Tobin at (850) 488-6949; FAX (850) 922-4084; or e-mail at keith@mail.co.leon.fl.us or tobind@mail.co.leon.fl.us. Written inquiries are preferred.

D. Special Accommodation: Any person requiring a special accommodation at a Pre-Bid Conference or Bid/RFP opening because of a disability should call the Division of Purchasing at (850) 488-6949 at least five (5) workdays prior to the Pre-Bid Conference or Bid/RFP opening. If you are hearing or speech impaired, please contact the Purchasing Division by calling the County Administrator's Office using the Florida Relay Service which can be reached at 1(800) 955-8771 (TDD).

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
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E. Proposers are expected to carefully examine the scope of services, and evaluation criteria and all general and special conditions of the request for proposals prior to submission. Each Vendor shall examine the RFP documents carefully; and, no later than seven (7) calendar days prior to the date for receipt of proposals, he shall make a written request to the Owner for interpretations or corrections of any ambiguity, inconsistency, or error which he may discover. All interpretations or corrections will be issued as addenda. The County will not be responsible for oral clarifications.

Only those communications which are in writing from the County may be considered as a duly authorized expression on the behalf of the Board. Also, only those communications from firms which are in writing and signed will be recognized by the Board as duly authorized expressions on behalf of proposers.

F. Your response to the RFP must arrive at the above listed address no later than _____, 2005 at 2:00 PM to be considered.

G. Responses to the RFP received prior to the time of opening will be secured unopened. The Purchasing Agent, whose duty it is to open the responses, will decide when the specified time has arrived and no proposals received thereafter will be considered.

H. The Purchasing Agent will not be responsible for the premature opening of a proposal not properly addressed and identified by Proposal number on the outside of the envelope/package.

I. It is the Proposers responsibility to assure that the proposal is delivered at the proper time and location. Responses received after the scheduled receipt time will be marked "TOO LATE' and may be returned unopened to the vendor.

J. The County is not liable for any costs incurred by bidders prior to the issuance of an executed contract.

K. Firms responding to this RFP must be available for interviews by County staff and/or the Board of County Commissioners.

L. The contents of the proposal of the successful firm will become part of the contractual obligations.

M. Proposal must be typed or printed in ink. All corrections made by the Proposer prior to the opening must be initialed and dated by the Proposer. No changes or corrections will be allowed after proposals are opened.

N. If you are not submitting a proposal, please return the form attached at the end of the RFP, marked 'No Proposal'.

O. The County reserves the right to reject any and/or all proposals, in whole or in part, when such rejection is in the best interest of the County. Further, the County reserves the right to withdraw this solicitation at any time prior to final award of contract.

P. Cancellation: The contract may be terminated by the County without cause by giving a minimum of thirty (30) days written notice of intent to terminate. Contract prices must be maintained until the end of the thirty (30) day period. The County may terminate this agreement at any time as a result of the contractor's failure to perform in accordance with these specifications and applicable contract. The County may retain/withhold payment for nonperformance if deemed appropriate to do so by the County.

RFP Title: Request for Proposals for Employee Medical Coverage
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Q. Public Entity Crimes Statement: Respondents must complete and submit the enclosed Public Entity Crimes Statement. A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

R. Certification Regarding Debarment, Suspension, and Other Responsibility Matters: The prospective primary participant must certify to the best of its knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency and meet all other such responsibility matters as contained on the attached certification form.

S. Licenses and Registrations: The contractor shall be responsible for obtaining and maintaining throughout the contract period his or her city or county occupational license and any licenses required pursuant to the laws of Leon County, the City of Tallahassee, or the State of Florida. Every vendor submitting a bid on this invitation for bids **shall** include a copy of the company's local business or occupational license(s) or a written statement on letterhead indicating the reason no license exists. Leon County, Florida-based businesses are required to purchase an Occupational License to conduct business within the County. Vendors residing or based in another state or municipality, but maintaining a physical business facility or representative in Leon County, may also be required to obtain such a license by their own local government entity or by Leon County. For information specific to Leon County occupational licenses please call (850) 488-4735.

If the contractor is operating under a fictitious name as defined in Section 865.09, Florida Statutes, proof of current registration with the Florida Secretary of State **shall be submitted** with the bid. A business formed by an attorney actively licensed to practice law in this state, by a person actively licensed by the Department of Business and Professional Regulation or the Department of Health for the purpose of practicing his or her licensed profession, or by any corporation, partnership, or other commercial entity that is actively organized or registered with the Department of State **shall submit** a copy of the current licensing from the appropriate agency and/or proof of current active status with the Division of Corporations of the State of Florida or such other state as applicable.

Failure to provide the above required documentation may result in the bid being determined as non-responsive.

T. Audits, Records, And Records Retention

The Contractor shall agree:

1. To establish and maintain books, records, and documents (including electronic storage media) in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided by the County under this contract.

2. To retain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to this contract for a period of five (5) years after termination of the contract, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the

records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract.

3. Upon completion or termination of the contract and at the request of the County, the Contractor will cooperate with the County to facilitate the duplication and transfer of any said records or documents during the required retention period as specified in paragraph 1 above.

4. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by Federal, state, or other personnel duly authorized by the County.

5. Persons duly authorized by the County and Federal auditors, pursuant to 45 CFR, Part 92.36(I)(10), shall have full access to and the right to examine any of provider's contract and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

6. To include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

U. Monitoring

To permit persons duly authorized by the County to inspect any records, papers, documents, facilities, goods, and services of the provider which are relevant to this contract, and interview any clients and employees of the provider to assure the County of satisfactory performance of the terms and conditions of this contract.

Following such evaluation, the County will deliver to the provider a written report of its findings and will include written recommendations with regard to the provider's performance of the terms and conditions of this contract. The provider will correct all noted deficiencies identified by the County within the specified period of time set forth in the recommendations. The provider's failure to correct noted deficiencies may, at the sole and exclusive discretion of the County, result in any one or any combination of the following: (1) the provider being deemed in breach or default of this contract; (2) the withholding of payments to the provider by the County; and (3) the termination of this contract for cause.

V. Addenda To Specifications

If any addenda are issued after the initial specifications are released, the County will post the addenda on the Leon County website at http://www.co.leon.fl.us/purchasing/. For those projects with separate plans, blueprints, or other materials that cannot be accessed through the internet, the Purchasing Division will make a good faith effort to ensure that all registered bidders (those vendors who have been registered as receiving a bid package) receive the documents. It is the responsibility of the vendor prior to submission of any proposal to check the above website or contact the Leon County Purchasing Division at (850) 488-6949 to verify any addenda issued. The receipt of all addenda must be acknowledged on the response sheet.

III. SCOPE OF SERVICES:

Leon County is seeking fully insured quotes fro employee medical coverage. Leon County is requesting vendors to propose on a:

1. Fully Insured HMO
2. Fully Insured PPO
3. Fully Insured POS Plan

Leon County reserves the right to reject any/or all proposals and to make awards as they may appear to be advantageous to the County; to hold proposals for 60 days from the submission date

without action, and to waive all formalities in proposal process. Your proposal may include any or all of the following:

Submissions should include quotes which assume both:
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ALL SUBMISSIONS WILL BE COMPARED TO THE CURRENT MEDICAL PLANS AS A BASELINE FOR QUALITY AND COST.

IF DEVIATIONS ARE MADE FROM THE CURRENT PLAN, PLEASE EXPLAIN THE DIFFERENCES.

III. SCOPE OF SERVICES

A. Leon County requests you respond in your proposal on how you would structure and provide group health coverage for its 1,300+ employees, retirees and dependents. Creative integration of Section 125 Cafeteria Plan concepts are strongly encouraged. It is desired that the benefits program proposed maximize participant opportunity to take full advantage of the pre-tax payment of these benefits, in accordance with law, and to limit employer costs to the greatest extent possible while still providing a quality offering of benefits. An effective Wellness Program is beneficial to the reduction of overall medical claims and loss of quality of life. Consequently, the proposal must include a significant wellness element to achieve improved health conditions for participants

The following sections and Attachment A, General Information contain further information on the Scope of Work and detailed requirements for developing proposals.

B. Coverage shall be effective January 1, 2006 or on a later date requested, in writing, to the bidder by the County. Coverage shall be guaranteed for a minimum of 12 months from the effective date at the same premium rate quoted in the bid. It is the County's intent to renew the coverage after the initial coverage period by negotiation with the bidder. Such renewal process may be conducted annually. The County must be notified 90 days in advance of the contract anniversary date of any premium increases.

C. If exceptions from coverage are made, exceptions must be clearly stated on each coverage.

D. Each respondent is required to examine carefully the specifications and risks to be covered. It will be assumed that the bidder has made such investigations and is fully informed as to the extent and character of the hazards and requirements of the specifications. No warranty is made or implied as to information contained in these specifications.

E. All proposals shall show or conform to the following, in addition to other information required in the proposal:

1. Name of proposed insurance company;
2. Insurance company rating from A.M. Best's Insurance Guide or appropriate financial documents to assure the bidder is a stable, sound, and responsible company. Only companies rated "A" or better will be considered; and
3. Insurance companies must be authorized to do business in the State of Florida and provide a certificate of authority.

F. Cancellation, termination, or expiration of the policy/coverage by the insurer/provider or insured/participant shall require 90 days notice.

G. All respondents must agree in writing to furnish the County with at least a quarterly report of all incurred claims. The reports must also include:

1. a specific analysis of claims over $50,000,
2. diagnosis and prognosis of all claims,
3. claims detail which includes a specific and aggregate analysis
4. network utilization analysis which includes in-network and out of network claims detail
5. hospital utilization and diagnosis report which includes hospitals, days and costs
6. breakdown of claims by categories (inpatient, outpatient, physician office, prescription, etc)

H. All respondents must agree to furnish an annual statement of loss experience within 15 days following the anniversary of the policy, including a detailed analysis of pending claims.

I. Policies/plans to cover any new employees shall be in accordance with HIPAA.

J. No proposal shall be withdrawn for a period of 90 days subsequent to the opening of the proposals, without consent of the County.

K. Successful contractor shall be required to provide on-site training and a question-and-answer session for all County employees. Also, the successful contractor shall be required to provide a toll-free customer service line between 8 a.m. and 5 pm each work day for County employee access to the insurance provider. User-friendly claim forms shall be furnished to the County with detailed instructions that can be provided to employees.

L. The County reserves the right to:
   1. Reject any or all proposals tendered
   2. Negotiate exclusively with one or more vendors of choice
   3. Terminate or modify the process at any time.

M. The County retains the right to reject all proposals submitted. The County is not required to select the proposal with the lowest pricing, but shall take into consideration other factors such as ability to service the contract, retention charges, past experience, financial stability, and other relevant criteria. The County reserves the right to accept any proposal deemed advantageous to the County. Please indicate if your firm is a small, minority, or women owned business.

IV. REQUIRED SUBMITTALS:

Proposers may propose on any one or more of the following coverage options. Please indicate which options you are submitting for proposal.

1. Fully Insured HMO
2. Fully Insured PPO
3. Fully Insured POS

There are questionnaires for each type of plan that must be answered as part of your proposal and are included as Attachments C - -The general questionnaire "ADMINISTRATIVE SERVICES & CLAIMS ADMINISTRATION - ALL PLANS" in Attachment B will need to be completed for ALL plan proposals along with the respective questionnaire for each option.

Your proposal must conform to the following format with information provided and labeled in accordance with the following sections.

A. Firm name, business address and office location, telephone and fax numbers, and designated company representative for this proposal and his/her contact information.

B. Federal Identification Tax Number.

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C. The age of the firm, brief history, and average number of employees over the past five years.

D. Names and descriptions of contracts with no less than 5 major employers for which the firm is presently under contract. Provide name, telephone and fax numbers for the employer's contract manager.

E. Provide participation information and acknowledgment of the Leon County Minority/Women Business Enterprise and Equal Employment Policies, Statement on Public Entity Crimes, Insurance Certification, and Certification Regarding Debarment (forms attached).

F. Cover Letter and written proposal providing overview of your proposed coverage as it relates to the requirements of this RFP. Be sure to adequately cover all items requested in this RFP that are not listed in the following sections G through M.

G. Completed questionnaire - ADMINISTRATIVE SERVICES & CLAIMS ADMINISTRATION - ALL PLANS

H. Completed questionnaire for specific plan coverage being proposed.

I. Sample Reports

J. Sample enrollment and promotional materials

K. Samples of standard communications to covered employees

L. Physician and Hospital Network Provider Listing

M. Miscellaneous

V. SELECTION PROCESS

A. The County Administrator shall appoint an Evaluation Committee composed of three to five members who will review all proposals received on time, and select one or more firms for interview based on the responses of each proposer. All meetings of Evaluation Committees subsequent to the opening of the solicitation shall be public meetings. Notice of all meetings shall be posted in the Purchasing Division Offices no less than 72 hours (excluding weekends and holidays) and all respondents to the solicitation shall be notified by facsimile or telephone.

B. The Evaluation Committee will recommend to the Board of County Commissioners (BCC), in order of preference (ranking), up to three (3) firms deemed to be most highly qualified to perform the requested services.

C. The (BCC) will negotiate with the most qualified firm (first ranked firm) for the proposed services at compensation which the BCC determines is fair, competitive, and reasonable for said services.

D. Should the BCC be unable to negotiate a satisfactory contract with the firm considered to be fair, competitive and reasonable, negotiations with that firm shall be formally terminated. The County shall then undertake negotiations with the second most qualified firm. Failing accord with the second most qualified firm the Board shall terminate negotiations. The BCC representative shall then undertake negotiations with the third most qualified firm.

E. Should the County be unable to negotiate a satisfactory contract with any of the selected firms, the Board representative shall select additional firms to continue negotiations.

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F. Evaluation Criteria: Proposals will be evaluated and ranked on the basis of these factors:

Scope of services, plan design, and integration of plan functions	15%
Quality of service contracts, customer service and location of services	15%
Cost of services	15%
Financial stability and responsiveness	10%
Reporting capabilities, interface with vendors, on-line capabilities	5%
References and experience with similar clients	10%
Multi-year rate guarantees	10%
Minority Vendor Participation	10%
Physician and Hospital Network	10%

VI. INDEMNIFICATIONS:

The Contractor agrees to indemnify and hold harmless the County from all claims, damages, liabilities, or suits of any nature whatsoever arising out of, because of, or due to the breach of this agreement by the Contractor, its delegates, agents or employees, or due to any act or occurrence of omission or commission of the Contractor, including but not limited to costs and a reasonable attorney's fee. The County may, at its sole option, defend itself or allow the Contractor to provide the defense. The Contractor acknowledges that ten dollars ($10.00) of the amount paid to the Contractor is sufficient consideration for the Contractor's indemnification of the County.

VII. MINORITY/WOMEN BUSINESS ENTERPRISE AND EQUAL OPPORTUNITY POLICIES

A. Minority/Women Business Enterprise Requirements

It is the policy of the Leon County Board of County Commissioners to institute and maintain an effective Minority/Women Business Enterprise Program. This program shall:

1. Eliminate any policies and/or procedural barriers that inhibit M/WBE participation in our procurement process.

2. Established goals designed to increase M/WBE utilization.

3. Provide increased levels of information and assistance available to M/WBEs.

4. Implement mechanisms and procedures for monitoring M/WBE compliance by prime contractors.

Each bidder is strongly encouraged to secure M/WBE participation through purchase of those goods or services to be provided by others. Firms responding to this RFP are hereby made aware of the County's goals for M/WBE utilization. Respondents should contact Agatha Muse-Salters, Leon County M/WBE Director, at phone (850) 488-7509; fax (850) 487-0928 for additional information. Respondents must complete and submit the attached Minority/Women Business Enterprise Participation Plan form. **Failure to submit the form will result in a determination of non-responsiveness for your proposal.**

As a part of the selection process for this project, the ranking procedure will provide a maximum of ten (10) percent of the total score where M/WBE's are used as follows:

M/WBE Participation Level		Points
_____	The respondent is certified as a Minority/Woman Business Firm with Leon County, as defined in the County's M/WBE policy.	10

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_____ The respondent is a joint venture of two or more firms/individuals with a minimum participation in the joint venture of at least 20% by certified minority/women business firms/individuals. 8

_____ The respondent has certified that a minimum of 15.5% of the ultimate fee will be subcontracted to certified M/WBE Firm(s), and has identified in the proposal the M/WBE Firm(s) that it intends to use. 6

B. Equal Opportunity/Affirmative Action Requirements

The contractors and all subcontractors shall agree to a commitment to the principles and practices of equal opportunity in employment and to comply with the letter and spirit of federal, state, and local laws and regulations prohibiting discrimination based on race, color, religion, national region, sex, age, handicap, marital status, and political affiliation or belief.

For federally funded projects, in addition to the above, the contractor shall agree to comply with Executive Order 11246, as amended, and to comply with specific affirmative action obligations contained therein.

In addition to completing the Equal Opportunity Statement, the Respondent shall include a copy of any affirmative action or equal opportunity policies in effect at the time of submission.

VIII. INSURANCE

Your attention is directed to the insurance requirements below. Respondents should confer with their respective insurance carriers or brokers to determine in advance of bid submission the availability of insurance certificates and endorsements as prescribed and provided herein. If a respondent fails to comply strictly with the insurance requirements, that respondent may be disqualified from award of the contract.

Contractor shall procure and maintain for the duration of the contract, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees, or subcontractors. The cost of such insurance shall be included in the Contractor's pricing.

1. Minimum Limits of Insurance: Contractor shall maintain limits no less than:

   a. General Liability: $1,000,000 Combined Single Limit for bodily injury and property damage per occurrence with a $2,000,000 annual aggregate.

   b. Automobile Liability: One Million and 00/100 ($1,000,000.00) Dollars combined single limit per accident for bodily injury and property damage. ***(Non-owned, Hired Car)***.

   c. Workers' Compensation Employers Liability: Insurance covering all employees meeting Statutory Limits in compliance with the applicable state and federal laws and Employer's Liability with a limit of $500,000 per accident, $500,000 disease policy limit, $500,000 disease each employee. ***Waiver of Subrogation in lieu of Additional Insured is required.***

   d. Professional Liability Insurance, including errors and omissions: for all services provided under the terms of this agreement with minimum limits of Five Million and 00/100 ($5,000,000.00) Dollars per occurrence; or claims made form with "tail coverage" extending three (3) years beyond the term of the agreement. Proof of "tail coverage" must be submitted with the invoice for final payment. In lieu of "tail coverage",

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Contractor may submit annually to the County a current Certificate of Insurance proving claims made insurance remains in force throughout the same three (3)-year period.

2. Deductibles and Self-Insured Retentions: Any deductibles or self-insured retentions must be declared to and approved by the County. At the option of the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Contractor shall procure a bond guaranteeing payment of losses and related investigations, claim administration, and defense expenses.

3. Other Insurance Provisions: The policies are to contain, or be endorsed to contain, the following provisions:

   a. General Liability and Automobile Liability Coverages ***(County is to be named as Additional Insured).***

      1) The County, its officers, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of activities performed by or on behalf of the Contractor, including the insured's general supervision of the Contractor; products and completed operations of the Contractor; premises owned, occupied or used by the Contractor; or automobiles owned, leased, hired or borrowed by the Contractor. The coverage shall contain no special limitations on the scope of protections afforded the County, its officers, officials, employees or volunteers.

      2) The Contractor's insurance coverage shall be primary insurance as respects the County, it officers, officials, employees and volunteers. Any insurance of self-insurance maintained by the County, its officers, officials, employees or volunteers shall be excess of the Contractor=s insurance and shall not contribute with it. Contractor hereby waives subrogation rights for loss or damage against the county.

      3) Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the county, its officers, officials, employees or volunteers.

      4) The Contractor's insurance shall apply separately to each insured against whom claims is made or suit is brought, except with respect to the limits of the insurer=s liability.

      5) Companies issuing the insurance policy, or policies, shall have no recourse against the County for payment of premiums or assessments for any deductibles with are all at the sole responsibility and risk of Contractor.

   b. All Coverages: Each insurance policy required by this clause shall be endorsed to state that coverage shall not be suspended, voided, canceled by either party, reduced in coverage or in limits except after thirty (30) days prior written notice by certified mail, return receipt requested, has been given to the County.

4. Acceptability of Insurers: Insurance is to be placed with insurers with a Best's rating of no less than A:VII.

5. Verification of Coverage: Contractor shall furnish the County with certificates of insurance and with original endorsements effecting coverage required by this clause. The certificates and endorsements for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. All certificates and endorsements are to be received and approved by the County before work commences. The County reserves the right to

require complete, certified copies of all required insurance policies at any time.

6. Subcontractors: Contractors shall include all subcontractors as insureds under its policies or shall furnish separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to all of the requirements stated herein.

IX. ETHICAL BUSINESS PRACTICES

A. Gratuities. It shall be unethical for any person to offer, give, or agree to give any County employee, or for any County employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, or preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing, or performing in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy, or other particular matter, subcontract, or to any solicitation or proposal therefor.

B. Kickbacks. It shall be unethical for any payment, gratuity, or offer of employment to be made by or on behalf of a subcontractor under a contract to the prime contractor or higher tier subcontractor or any person associated therewith, as an inducement for the award of a subcontract or order.

C. The Board reserves the right to deny award or immediately suspend any contract resulting from this proposal pending final determination of charges of unethical business practices. At its sole discretion, the Board may deny award or cancel the contract if it determines that unethical business practices were involved.

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PROPOSAL RESPONSE COVER SHEET

This page is to be completed and included as the cover sheet for your response to the Request for Proposals.

The Board of County Commissioners, Leon County, reserves the right to accept or reject any and/or all bids in the best interest of Leon County.

Keith M. Roberts, Purchasing Director

Cliff Thaell, Chairman
Leon County Board of County Commissioners

This bid response is submitted by the below named firm/individual by the undersigned authorized representative.

_____
(Firm Name)

BY _____
(Authorized Representative)

_____
(Printed or Typed Name)

ADDRESS _____

_____

CITY, STATE, ZIP _____

TELEPHONE _____

FAX _____

ADDENDA ACKNOWLEDGMENTS: (IF APPLICABLE)

Addendum #1 dated _____ Initials _____

Addendum #2 dated _____ Initials _____

Addendum #3 dated _____ Initials _____

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STATEMENT OF NO BID

We, the undersigned, have declined to respond to the above referenced RFP for the following reasons:

_____ We do not offer this service

_____ Our schedule would not permit us to perform.

_____ Unable to meet specifications

_____ Others (Please Explain)

_____

_____

_____

_____

We understand that if the no-bid letter is not executed and returned, our name may be deleted from the list of qualified bidders for Leon County.

Company Name _____

Signature _____

Name (Print/Type) _____

Telephone No. _____

FAX No. _____

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SWORN STATEMENT UNDER SECTION 287.133(3)(a), FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to Leon County Board of County Commissioners

   by_____
   [print individual's name and title]

   for_____
   [print name of entity submitting sworn statement]

   whose business address is: _____

   _____

   and (if applicable) its Federal Employer Identification Number (FEIN) is _____.
   (If the entity has no FEIN, include the Social Security Number of the individual signing this sworn

   statement:_____).

2. I understand that a "public entity crime" as defined in Paragraph 287.133(1)(g), Florida Statutes, means a violation of any state or federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including, but not limited to, any bid or contract for goods or services to be provided to any public entity or an agency or political subdivision of any other state or of the United States and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

3. I understand that "convicted" or "conviction" as defined in Paragraph 287.133(1)(b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that an "affiliate" as defined in Paragraph 287.133(1)(a), Florida Statutes, means:

   a. A predecessor or successor of a person convicted of a public entity crime: or
   b. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5. I understand that a "person" as defined in Paragraph 287.133(1)(e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact

   business with a public entity. The term "person" includes those officers, directors, executives,

partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. [Indicate which statement applies.]

_____ Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However there has been a subsequent proceeding before a hearing a Hearing Officer of the State of Florida, Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. [Attach a copy of the final order.]

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND, THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, FLORIDA STATUTES FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

_____
(signature)

Sworn to and subscribed before me this _____ day of _____, 20___.

Personally known _____ OR Produced identification _____
(Type of identification)

_____
NOTARY PUBLIC

Notary Public - State of _____

My commission expires: _____

_____
Printed, typed, or stamped commissioned name of notary public

MINORITY/WOMEN BUSINESS ENTERPRISE PARTICIPATION PLAN

RESPONDENT_____

MBE Participation Levels		Points
_____	The respondent is certified as a Minority/Woman Business Firm with Leon County, as defined in the County's M/WBE policy.	10
_____	The respondent is a joint venture of two or more firms/individuals with a minimum participation in the joint venture of at least 20% by certified minority/women business firms/individuals.	8
_____	The respondent has certified that a minimum of 15.5% of the ultimate fee will be subcontracted to certified M/WBE Firm(s), and has identified in the proposal the M/WBE Firm(s) that it intends to use.	6

M/WBE firms and subcontractors must be certified by the City of Tallahassee or Leon County to qualify for M/WBE participation credit. Please provide the following information for each M/WBE. Please indicate minority groups by using the corresponding letters: African American (B), Asian American (A), Hispanic American (H), Native American (N) and Non Minority Female (F). **You must submit proof of certification with your proposal.** Attach additional sheets as necessary.

Name, Address, and Phone	Materials/Services	Amount	Group

Total Value of M/WBE Participation: $ _____
Total Project Base Bid: $ _____
M/WBE Participation as % of Total Base Bid: _____%

The vendor acknowledges the Leon County M/WBE policy and the provisions specified for this RFP. If applicable, vendor certifies that the above list of minority vendors and the respective contract amounts and percentages of the total bid are accurate.

Signed: _____ Title: _____ Date_____

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EQUAL OPPORTUNITY/AFFIRMATIVE ACTION STATEMENT

1. The contractors and all subcontractors hereby agree to a commitment to the principles and practices of equal opportunity in employment and to comply with the letter and spirit of federal, state, and local laws and regulations prohibiting discrimination based on race, color, religion, national region, sex, age, handicap, marital status, and political affiliation or belief.

2. The contractor agrees to comply with Executive Order 11246, as amended, and to comply with specific affirmative action obligations contained therein.

Signed: _____

Title: _____

Firm: _____

Address: _____

_____

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INSURANCE CERTIFICATION FORM

To indicate that Bidder/Respondent understands and is able to comply with the required insurance, as stated in the bid/RFP document, Bidder/Respondent shall submit this insurances sign-off form, signed by the company Risk Manager or authorized manager with risk authority.

A. Is/are the insurer(s) to be used for all required insurance (except Workers' Compensation) listed by Best with a rating of no less than A:VII?

☐ YES ☐ NO

Commercial General Liability:	Indicate Best Rating: Indicate Best Financial Classification:	_____ _____
Business Auto:	Indicate Best Rating: Indicate Best Financial Classification:	_____ _____
Professional Liability:	Indicate Best Rating: Indicate Best Financial Classification:	_____ _____

1. Is the insurer to be used for Workers' Compensation insurance listed by Best with a rating of no less than A:VII?

☐ YES ☐ NO

Indicate Best Rating: _____
Indicate Best Financial Classification: _____

If answer is NO, provide name and address of insurer:

_____

_____

_____

2. Is the Respondent able to obtain insurance in the following limits (next page) for this professional services agreement?

☐ YES ☐ NO

Insurance will be placed with Florida admitted insurers unless otherwise accepted by Leon County. Insurers will have A.M. Best ratings of no less than A:VII unless otherwise accepted by Leon County.

Required Coverage and Limits

The required types and limits of coverage for this bid/request for proposals are contained within the solicitation package. Be sure to carefully review and ascertain that bidder/proposer either has coverage or will place coverage at these or higher levels.

Required Policy Endorsements and Documentation

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Certificate of Insurance will be provided evidencing placement of each insurance policy responding to requirements of the contract.

Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions must be declared to and approved by the County. At the option of the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Contractor shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

Endorsements to insurance policies will be provided as follows:

Additional insured (Leon County, Florida, its Officers, employees and volunteers) - General Liability & Automobile Liability

Primary and not contributing coverage- General Liability & Automobile Liability

Waiver of Subrogation (Leon County, Florida, its officers, employees and volunteers)- General Liability, Automobile Liability, Workers' Compensation and Employer's Liability

Thirty days advance written notice of cancellation to County - General Liability, Automobile Liability, Worker's Compensation & Employer's Liability.

Professional Liability Policy Declaration sheet as well as claims procedures for each applicable policy to be provided

Please mark the appropriate box:

Coverage is in place ☐ Coverage will be placed, without exception ☐

The undersigned declares under penalty of perjury that all of the above insurer information is true and correct.

Name _____ Signature _____
Typed or Printed

Date _____ Title _____
(Company Risk Manager or Manager with Risk Authority)

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CERTIFICATION REGARDING DEBARMENT, SUSPENSION, And OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:

   a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

   b) Have not within a three-year period preceding this been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statues or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of these offenses enumerated in paragraph (1)(b) of this certification; and

   d) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

3. No subcontract will be issued for this project to any party which is debarred or suspended from eligibility to receive federally funded contracts.

_____
Signature

_____
Title

_____
Contractor/Firm

_____
Address

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ATTACHMENT A
GENERAL INFORMATION

I. Current Plan Information

A. The group is comprised of the employees, retirees and dependents of the Leon County Board of County Commissioners, Supervisor of Elections, Clerk of the Courts, Property Appraiser, Sheriff, and Tax Collector..

B. At a future date, the County may be involved in a health care consortium with the Leon County School Board and the City of Tallahassee. This may include a joint request for proposal on all plan options indicated in this Proposal.

C. There are approximately ____ employees in the present group working for the Board of Commissioners and Constitutional Offices of County government:

1. Board of County Commissioners -
2. Clerk of the Courts -
3. Sheriff's Department (includes Jail) -
4. Supervisor of Elections -
5. Tax Collector -
6. Property Appraiser -

D. Approximately —— employees are under individual coverage. Approximately —— employees are under employee and spouse coverage. Approximately —— employees are under employee and child(ren) coverage. Approximately —— employees are under full family coverage.

E. A copy of our latest census, dated _____ 2005 is attached as Attachment _.

F. Leon County is currently in a fully-insured HMO health plan with Capital Health Plan and VISTA.

G. Currently, Leon County pays 92.5% of the cost of employee and family coverage. Employees contribute 7.5%.

Employees may choose to pay for certain of their benefits on a pre-tax basis under Leon County's Internal Revenue Code (IRC) Section 125 cafeteria plan. In addition, employees can utilize a medical and/or dependent care flexible spending account. The Flexible Spending Account is being administered by the Fringe Benefit Management Company.

H. New Hires have 30 days to enroll in coverage. Employees and their eligible dependents are covered effective the first day of the month following date of application. Employees may Opt-Out of the Medical Plan provided they can provide proof of other coverage outside of LCBCC. Employees receive $300 per month for opting out of the Medical Plan.

II. Proposed Plan Specifications

A. All offers must provide the following:

1. Deductible and waiting period credit;
2. No lost benefits due to transfer of coverage;
3. Immediate maternity benefits for insured; and
4. Immediate coverage of transferred COBRA participants, Retirees, and employees on a leave of absence.

5. No Pre-existing conditions or actively at work provisions
6. Transition of Care benefit

B. Proposed Group Health Coverage

The proposals shall provide coverage for the following:

1. Full-time employees; and part time employees working at least 20 hours per week who have been employed for 2 years.
2. Dependents of covered employees, which include:
   a) Legally married spouse;
   b) Unmarried natural or adopted children up to 25 years of age, if enrolled in a state-approved educational or technical institution;
   c) Stepchildren;
   d) Grandchildren, if employee is legal guardian;
   e) Any dependent claimed on the employee's federal income tax return.
3. Medicare. Benefit coordination as per federal law or regulations.
4. The successful bidder will comply with all COBRA and HIPAA requirements.

C. Guaranteed Rates

All rates shall be guaranteed for 12 months beginning January 1, 2006. However, The County reserves the right to accept a guarantee of more than 12 months if it is in the County's best interest. Multi-year rate guarantees are strongly recommended and will be a consideration in the evaluation process. All guarantees should be explained in your quote.

Leon County requires a minimum rate guarantee of 12 months. Please confirm this guarantee in your response. Leon County prefers a multi-year contract. ***To enter into a multi-year contract, the County requires you to include a method for calculating the increase for each option year in the contract***. Leon County prefers a method of calculation based on an objective standard related to its performance. Clearly indicate a method of calculating the increase in your response for each option period. ***If you are basing the rate of increase on our claims detail, please explain your methodology***. The contract is to provide that changes in premium can only be instituted on a policy anniversary date and that the selected proposer must provide for notice of changes in premium at least 90 days before renewal.

D. Information Provided to Insurers

Data regarding Leon County employee census, claims experience, schedule of benefits, rate history, etc., are provided in these specifications and attachments are to be used specifically to aid in the underwriting and issuance of a proposal for Leon County's employee benefits. Any unauthorized use of this information will be cause for immediate termination of any existing or future contracts.

E. Term of Contract and Extension/Renewal Rights

The term of the contract(s) issued as a result of this request for proposal shall be for not less than one year, subject to earlier termination as provided by law and by the terms of the contract. In addition, unless otherwise specified in the proposal, the award of this contract shall include the right at the option of the County, contingent upon the agreement by both parties to any change in premium costs or benefits, to renew and extend this contract on a year-to-year basis as may be permitted by applicable law and County Policy.

It is the County's intent to award a contract for a 3 year period, with 3 one year extension options, at the discretion on the County. If all extension options were exercised, the maximum total term of the agreement would be 6 years.

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F. Role of Consultant

The County will retain an independent consultant to provide medical plan consulting services in the RFP review, evaluation and analysis process.

G. Cost of Preparation

The County will not reimburse any Proposer for any costs associated with the preparation and submittal of any proposal, or for any travel and per diem costs that are incurred by any Proposer in preparation and submittal of any proposal.

III. GENERAL REQUIREMENTS

A. Requirements of Companies and Agents Submitting Proposals

1. It is the intent of Leon County that covered employees and covered dependents shall not lose or gain benefits as a result of a change in carrier. This is commonly referred to as "No loss/No Gain." Leon County requires that the pre-existing condition limitations and the actively at work provision be waived for the initial enrollment for those employees who have already satisfied the waiting period for pre-existing conditions under the current plan. Please confirm your agreement with this provision.

2. The selected offeror will be responsible for all claims incurred on or after the effective date and within the contract period. An appropriate transition program will need to be developed before the effective date.

3. The selected offerors for all coverage's should have the capability of electronic data interchange for eligibility and other records for bi-directional transfer of data files upon transition and on an ongoing basis.

4. All Companies submitting proposals must be licensed by the State of Florida and have a demonstrated level of good performance with public entities, including Counties.

5. Any Company Agent or Third Party Administrator must have an errors and omissions policy with a minimum limit of $1,000,000. Please enclose proof with your proposal.

6. Insurance Companies must be recommended in the latest edition of Best's Life Insurance Reports with a general policy holder's rating of A or better. Leon County must be furnished the Best's policyholder rating for each company with which coverage is being quoted.

7. A Lloyds Company shall be acceptable if it is an entity controlled by a company with a financial rating of A or better or a Guaranty Bond with proper power of attorney. Enclose with your proposal.

8. Companies must have a willingness to commit to specified levels of performance for service and quality.

9. Companies must have an organization that has demonstrated the ability to deliver cost-effective service, efficient loss control and claims processing.

10. Companies must provide sufficient telephone service, including toll-free and local service, to handle inquiries directly from plan participants as well as County business representatives.

11. All qualified organizations submitting proposals must disclose the following, if broker

fees are paid:
Name of agency and address;
Name of agent/broker; and
Broker's fee whether flat fee or percentage of premium.

If the above referenced disclosure is not applicable, please indicate that the proposal is quoted on a no-commission basis. It is the intention of the County for all contracts to be awarded on a no commission basis.

12. Must not include any "actively at work" clauses in contracts.

13. Proposer must assume current policy benefit structure and provide a "no loss/no gain" assumption of risk and credit for all annual deductibles, co-insurance, and major medical maximum benefits.

14. Proposer must comply with all recent federal legislation including but not limited to HIPPA, COBRA and Mental Health Parity.

15. Proposer should provide the names of three current and three terminated references that we may contact (including number of employees, location, contact and telephone number) that are similar in size and composition to Leon County.

    For these references, also please provide the following information:

    a) The services you provide to these clients;
    b) When the clients were underwritten and or terminated;
    c) Membership size of the clients.

16. Reporting requirements

    a) Claims paid by each insured unit EE, Spouse, Child.
    b) Claims paid by type of expense
    c) Claims exceeding $50,000 in the aggregate and claims that exceed 50% of the specific stop loss level.
    d) Claims submitted to Major Case Management.
    e) PPO savings, ineligible expenses, coordination of benefits, and deductible savings.
    f) Providers listed by utilization.
    g) Lag studies.
    h) Draft registers
    i) What is your charge for custom reports?
    j) Submit a copy of one page of each of your standard reports in your reporting package.
    k) Submit copy of your Sample ID card.
    l) Describe your electronic claims submission and adjudication capabilities.
        1) Are you presently able to accept and process claims from providers electronically via the Internet or secure data exchange?
        2) Do your systems presently meet electronic data interchange (EDI) requirements proposed by the Health Insurance Portability and Accountability Act (HIPAA)?
        3) Is your current claims payment process capable of meeting the required deadlines for initial claim determination and communication requirements for Urgent, Pre-Service and Post-Service claims as specified in the final ERISA Claims and Appeal Regulations?

17. Provide enrollment assistance to County during open enrollment on an annual basis.

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This could include, but is not limited to, providing educational materials on the Plan and having properly trained representatives attend Benefit Fairs and give educational presentations on the Plan.

18. PERFORMANCE AND SERVICE STANDARDS

A service standards agreement by the successful Proposer shall be executed prior to the execution of the contract between the parties. The successful Proposer is required to meet the following monthly performance standards. The County reserves the right to have an independent consultant, on a quarterly basis, review adherence to these service standards. Adherence is expected to each of these standards. This agreement is binding for the period of the contact, subject to mutually satisfactory modifications with the County reserving the right to impose non performance liquidated damages.

a. Average Claim Turnaround Time: 90% of all clean claims must be paid and Explanation of Benefit (EOB) mailed within 10 working days after claim submission.
b. Claims Status Report: Provide status to employees for claims not resolved within 30 days of claims submission.
c. Threatening Letter Response: Respond, in writing, directly to the letter writer, employee or covered dependent, and the County's Human Resources staff with an explanation of the claim status within 5 working days of receipt of notification, any time a County's employee or dependent receives a letter from a Provider threatening legal action, referral to a collection agency, or other negative action which could jeopardize the employee or dependent's credit standing because of the delay or failure in paying claims.
d. Financial and Claims Reports: Provide within 15 calendar days for monthly reports; 45 calendar days after end of period for quarterly or annual reports.
e. Payment Accuracy of Claims: Assess payment accuracy of claims through random sampling, on a quarterly basis, with error no greater than 2% .
f. Claims Account Reconciliation Accuracy: Assess accuracy of claims checks reconciliation and ability to balance the account, with no errors.

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
Opening Date:

ATTACHMENT B
QUESTIONNAIRE
ADMINISTRATIVE SERVICES & CLAIMS ADMINISTRATION - ALL PLANS

All respondents must complete this questionnaire under each category for which they are providing a proposal.

1. Briefly describe your ability to assume the County Plan.
   a. Number of claim processors at your location.
   b. Number of claim processors reserved for the County.
   c. Who would conduct the enrollment process?
   d. Name of individual responsible for County Plan.
   e. Submit brief resume on individuals you propose to handle the County contract.

2 Provide information on how you perform the following tasks:

   a. Provide either modem dial up or Internet access to allow the County to manage enrollment procedures in their office. What is the fee for this service?

   b. Check for duplicate charges

   c. Identify bundling and unbundling of charges

   d. Monitor accumulators in your system (Family deductibles, Max OOP, lifetime Max, deductibles, M&N max, Chiropractic Max)

   e. Track pending claims

   f. Monitor claims examiner performance

   g. Handle appeals from claimants

   h. What standard do you use to determine customary and reasonable charges outside of the negotiated fees for your PPO?

   i. Handle subrogation. Any additional fee for doing so?

   j. Verify eligibility

   k. Do you employ a medical advisor?

   l. Do you employee an actuary?

   m. How often would you suggest claim checks to be written?

3. Will you provide renewal and rate information 90 days prior to renewal? If not what is the earliest date renewal rate information will be made available?

4. Does your plan currently offer on-line access to claims and eligibility information? Is there a separate charge for this to the plan?

5. Describe how participants select network providers. Do you provide member support services for selecting and/or locating network providers?

6. Do you have on-line access to network provider listings and locations to assist members with provider selection?

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
Opening Date:

7. What assistance do you provide plan members if a network provider terminates their contract during the plan year? How and when are members notified? What happens to patients that are receiving on-going treatment from that network provider?

8. How do you provide transition of care and treatment of patients who are being treated by a physician that is not in your network.
   a. Maternity Coverage prior to the last trimester
   b. Maternity Coverage in the last trimester
   c. Ongoing cancer chemotherapy
   d. Disabled employees
   e. Hospitalized employees or dependents on the date of risk assumption. Specific and aggregate coverage may be in effect prior to the effective date based on the policy limits proposed.
   f. Not actively at work employees on the effective date.
   g. Employees on extended leave of absence.

9. Is eligibility available online to Human Resources staff?

10. Will there by a dedicated customer services unit for Leon County? If so, where will it be located and how will it be staffed?

11. Attach samples of your standard reporting package that is included in your quote. Please note if your paid claims numbers are based on paid or incurred claims figures.

12. Attach sample reports that are available but not included in standard package. How are these requested and what is the cost if any.

13. What is the average hold time for customer service calls? Please supply a sample phone unit report.

14. Contracted vendors will keep Leon County supplied with needed enrollment materials, as well as current provider directories. Please supply sample of material.

15. Leon County would like you to survey our employees annually to monitor the employees' satisfaction with your product and services. Do you currently do this? If so, please describe your process.

16. What is the average turnaround time for supplying ID cards directly to participants?

17. As a vendor you will work with Leon County on wellness programs and initiatives (such as annual flu shots, allergy clinics, healthy pregnancies)? If so, include a suggested plan or sample plans you have used for other employers.

18. Leon County requires the right to approve any general distribution type correspondence sent to our employees. Do you agree to the prior approval agreement?

19. Please indicate your process for handling subrogation claims?

20. Please define a "paid claim" as it pertains to your organization. (Please be specific, as to when a claim is received, processed, paid and checked cut)?

21. Please define a "clean claim" as it pertains to your organization.

22. Proposer must indicate how present policy benefit structures would relate to your proposed plan and provide a 'no loss/no gain" assumption of risk and credit for all annual deductibles, co-insurance, and major medical maximum benefits.

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
Opening Date:

ATTACHMENT C
FULLY INSURED PLAN – HEALTH MAINTENANCE ORGANIZATIONS QUESTIONNAIRE

Leon County is soliciting proposals for an HMO plan for its active and retired employees and their dependents and surviving spouses of retirees. The HMO plan option will be offered to those employees/ retirees/surviving spouses who reside or work in the network area. The provider network will need to include Centers of Excellence for various specialties, such as cardiac, oncology, and transplants.

There is no pre-existing conditions limitation on the medical plan. Qualified dependent children and grandchildren are eligible for coverage to the qualifying age of 25 years.

a. ***Proposals must provide rates for the current plan of benefits offered to the employees of Leon County***. Optional benefit plan designs will be accepted only if rates are provided for the current benefit plan. If unable, please provide written explanation.

b. Health Maintenance Organization should initially attempt to duplicate the benefit structure of Capital Health Plan and VISTA as closely as possible. Please note in your proposal significant differences in your plan of benefits. A spreadsheet comparing your proposed plan with the two current plans would aid in the interpretation of your proposal.

Please reproduce these questions when supplying your answers.

1. What are the smallest and largest plan participant populations that the Firm now handles?

2. Will the Firm provide personalized enrollment forms? If so, at what additional cost to the amounts shown on the fee schedule? Please provide a sample.

3. What information does the Firm need from Leon County initially and on an ongoing basis to fulfill its contract obligations? How frequently? In what format and medium?

4. Please provide samples of all forms, communications, reports, and statements that the Firm would use in administering the Plan.

5. Please provide evidence that the HMO is licensed to operate in the State of Florida and/or is qualified under Section 1310(d) of the Health Maintenance Organization Act. Please indicate the month and year licensing and/or qualifications were originally obtained.

6. Has the HMO or its officers or directors been involved in a lawsuit related to the HMO in the past five years? If yes, please explain.

7. How is case management handled? Where is it located? What is the process in the case of a referral by a PCP to an: out of area provider, or an out of network provider, or to a Center of Excellence such as MD Anderson Medical Center? How do you contract with Centers if at all? How would your employees access needed treatment?

8. Please provide a list of the Centers of Excellence you contract with if any.

9. How many of each of the following providers are in your health plan in Leon County and contingent counties in the Florida Service area?

    a) Hospitals
    b) Pharmacies
    c) PCP's (general/family practice; internal medicine, pediatrics) How many of the PCP's and OB/GYN 's are accepting new patients?

RFP Title: Request for Proposals for Employee Medical Coverage
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d) OB/GYN's
e) Allergists
f) All other specialties

10. Are urgent care centers part of your provider network?

11. Must PCP's refer and coordinate utilization management on behalf of the member (non-OB/GYN)?

12. Please identify those services which require prior approval of the case manager or medical director.

13. What is your voluntary and involuntary provider turnover rate?

14. Is a toll free number provided for employees regarding network referrals and other network (non-claims) information?

15. Is there a nurse advisory toll free line for employees to access? Any associated cost?

16. Leon County expects to be notified if any hospitals or major provider groups drop out of network. How will this be handled?

17. Please identify and explain your disease management programs. Are these programs provided at an added cost? What is the expected plan benefit and savings? How are savings identified and shared with policyholders?

18. Please provide a copy of all network directories for the proposed service area.

19. Do your directories provide a unique numeric identifier for each PCP in order to allow for PCP selections to be made through a telephone enrollment system or online?

20. Do you allow licensed "Enrollers" that the County may select to enroll your plan?

21. Leon County may carve out the prescription plan and contract directly with a PBM. Can you interface with various PBM's? Do you have a recommendation?

22. Please indicate your prescription plan, showing the rate separately.

23. Please indicate the brand names and/or trade names of the drugs in your formulary.

24. What is the average turnaround time for supplying ID cards directly to participants? How does an employee replace an ID card?

25. As a vendor, will you work with Leon County on wellness programs and initiatives (such as annual flu shots, allergy clinics, healthy pregnancies)? If so, provide a suggested plan or sample plans you have used for other companies.

26. Attach samples of your standard reporting package that is included in your quote. Please note if your paid claims numbers are based on paid or incurred claims figures.

27. Please indicate your process for handling subrogation claims.

28. Do your administration fees include the following:
    a. Postage
    b. Claim forms
    c. ID cards including mailing to participants
    d. Participating provider directories
    e. Customer service representatives specific to Leon County

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
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Financial – HMO

Provide a fully insured quote for the HMO plan by completing the following section, indicating the rates on a monthly basis for each of the following rate categories and employee classes:

Please show "factors" used in determining the formula for each tier. If any one tier is "weighted" please provide explanations.

Coverage	Rate
Employee Only	
Employee +1	
Employee + family	

Coverage	Rate
Retiree Only	
Retiree +1 Either Primary	
Retiree + 1 Both Primary	
Retiree + Family Either Primary	
Retiree + Family Both Primary	

Multi-year Fee Guarantee

Calendar 2006 Yes ( ) No ( )
Calendar 2007 Yes ( ) No ( )
Calendar 2008 Yes ( ) No ( )

If yes, please provide the formula for each year

Calendar 2006 _____
Calendar 2007 _____
Calendar 2008 _____

Please indicate prescription plan cost as included in proposal.

Coverage	Generic	Brand name	Non-Formulary
Employee only			
Employee + one			
Employee + family			

RFP Title: Request for Proposals for Employee Medical Coverage
Proposal Number: BC-00-00-05-00
Opening Date:

ATTACHMENT D
PPO PLAN – FULLY INSURED
QUESTIONNAIRE

General Information

Leon County currently does not offer a fully insured plan to active employees, retirees, surviving spouses and their dependents. Of prime importance is quality and size of network, as well as availability to Centers of Excellence when needed as a network provider. Leon County may directly contract with a limited number of providers and, if so, may need the payor and carrier to administer those contracts.

(Please reproduce these questions when supplying your answers.)

1. How is large case management handled? Where is it located? What happens in case an employee needs to access care outside the network? Out of area? At a Center of Excellence, such as M.D. Anderson Medical Center?

2. Leon County requires networks to have access to Centers of Excellence. How do you contract with the Centers? Through your own network or another type of arrangement? How will our employees access for needed treatment?

3. What is your average hold time for customer service calls? Please supply a sample phone unit report.

4. Our employees are effective the first of the month following receipt of their enrollment form. Employees have 30 days from their date of hire to submit their enrollment form to Human Resources. Will this present and problem? If so, please explain.

5. What is your voluntary and involuntary provider turnover rate?

		Voluntary	Involuntary
a.	Primary Care Physician	_____	_____
b.	OB/GYN	_____	_____
c.	Specialists (exclude OB/GYN)	_____	_____

6. Is a nurse advisory toll free number available? Is there any associated cost?

7. Leon County will need to be notified if a large provider group or a hospital in our service area dropped out of the network. Will this present a problem?

8. As a vendor will you work with Leon County on wellness programs and initiatives (such as annual flu shots, allergy clinics, healthy pregnancies)? If so, provide a suggested plan or sample plans you have used for other employers.

9. Attach samples of your standard reporting package that is included in standard package. How are these requested, and what is the cost if any?

10. Attach sample reports that are available but not included in standard package. How are these requested and what is the cost if any?

11. Please indicate your process for handling subrogation claims.

12. Please define "paid claim" as it pertains to your organization. (Please be specific as to when a claim is received, processed, paid and check cut).

13. Please define a "clean claim" as it pertains to your organization.

RFP Title: Request for Proposals for Employee Medical Coverage
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Opening Date:

14. Do your administration fees include the following:

    a. Postage
    b. Claim forms
    c. ID cards including mailing to participants
    d. Participating provider directories
    e. Customer service representative specific to Leon County

16. Will your organization collaborate with Leon County in preparing a detailed administrative manual including procedural information on all agreed upon plan administration and claims procedures?

17. Do you allow licensed "Enrollers" that the County may select to enroll your products?

18. What types of claims management services to you have in place?

19. What is the location of the claims processing site that would service Leon County?

20. What is the size of that location?
    a. Number of employees
    b. Weekly volume of claims
    c. Number of accounts over 3,000

21. What is your average claim processing time?

22. Will you provide a monthly paid claim summary?

23. Will you provide prior to fiscal year end, a preliminary account on claims, reserves, and estimated expenses?

24. Is eligibility available on line to Human Resources staff?

Financial – PPO-Fully Insured

Provide a fully insured quote for the PPO plan by completing the following section, indicating the rates on a monthly basis for each of the following rate categories and employee class:

Coverage	Rate
Employee Only	
Employee +1	
Employee + family	

Coverage	Rate
Retiree Only	
Retiree +1 Either Primary	
Retiree + 1 Both Primary	
Retiree + Family Both Primary	
Retiree + Family Either Primary	

Multi-year Fee Guarantee

Calendar 2006 Yes ( ) No ( )
Calendar 2007 Yes ( ) No ( )
Calendar 2008 Yes ( ) No ( )

RFP Title: Request for Proposals for Employee Medical Coverage
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Opening Date:

If yes, please provide the formula for each year

Calendar 2006 _____
Calendar 2007 _____
Calendar 2008 _____

Please indicate prescription plan cost as included in proposal.

Coverage	Generic	Brand name	Non-Formulary
Employee only			
Employee + one			
Employee + family			

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WILLIAM S. SIMON, SECRETARY

Suite 315

CERTIFICATION OF CONTRACT

TITLE: Benefit Consulting Services and Actuarial Services

CONTRACT NO.: 973-500-03-1

RFP NO.: 37-973-500-O

EFFECTIVE: October 15, 2002 through October 14, 2003
1ST RENEWAL: October 15, 2003 through October 14, 2004
2ND RENEWAL: October 15, 2004 through October 14, 2005
(Rev 14 Oct 04)

SUPERSEDES: New Contract

CONTRACTOR(S): Mercer Human Resource Consulting (A)
Milliman, Inc. (A)
Palmer & Cay Consulting of FL (A)

A. AUTHORITY - Upon affirmative action taken by the State of Florida Department of Management Services, a contract has been executed between the State of Florida and the designated contractors.

B. EFFECT - This contract was entered into to provide economies in the purchase of Benefit Consulting Services and Actuarial Services by all State of Florida agencies and institutions. Therefore, in compliance with Section 287.042, Florida Statutes, all purchases of these commodities shall be made under the terms, prices, and conditions of this contract and with the suppliers specified.

C. ORDERING INSTRUCTIONS - All purchase orders shall be issued in accordance with the attached ordering instructions. Purchaser shall order at the prices indicated, exclusive of all Federal, State and local taxes.

All contract purchase orders shall show the State Purchasing contract number, product number, quantity, description of item, with unit prices extended and purchase order totaled. (This requirement may be waived when purchase is made by a blanket purchase order.)

D. CONTRACTOR PERFORMANCE - Agencies shall report any vendor failure to perform according to the requirements of this contract on Complaint to Vendor, form PUR 7017. Should the vendor fail to correct the problem within a prescribed period of time, then form PUR 7029, Request for Assistance, is to be filed with this office.

E. SPECIAL AND GENERAL CONDITIONS - Special and general conditions are enclosed for your information. Any restrictions accepted from the supplier are noted on the ordering instructions.

F. CONTRACT APPRAISAL FORM - State Contract Appraisal, form PUR 7073 should be used to provide your input and recommendations for improvements in the contract to State Purchasing for receipt no later than 90 days prior to the expiration date of this contract.

_____

Authorized Signature (date)

TB/meb

Attachments

CONTRACT ADMINISTRATOR

TOM BUTLER

PHONE: (850) 488-7804

SUNCOM 278-7804

E-MAIL: butlert@dms.state.fl.us

Board of County Commissioners
Agenda Request

Date of Meeting: September 21, 2004

Date Submitted: September 15, 2004

To: Honorable Chairman and Members of the Board

From: Parwez Alam, County Administrator PA
Lillian Bennett, Director of Human Resources LWB

Subject: Renewal of Health Insurance Coverage for the 2005 Plan Year

Statement of Issue:

At the September 14, 2004 meeting, staff presented an agenda item requesting Board approval of the renewal rates and consideration of renewal options for the two group health insurance providers, Capital Health Plan (CHP) and Vista (formerly Health Plan Southeast) for the January 1, 2005 through December 31, 2005 plan year (Attachment #1). The Board continued the agenda item after a receipt of a proposal from United Health Care (United), a new provider to the Leon County service area, who is requesting Board approval to become a third provider of health insurance coverage for Leon County.

Background:

At the September 14, 2004 meeting, staff presented three (3) alternatives for Board consideration of health insurance coverage. Staff recommended Alternative #1, which maintains the current plan design, co-pays and health insurance providers (CHP and Vista) for the 2005 plan year (Attachment #1 – Table #2, page 3).

The County received an initial proposal from United Health Care (United) as another alternative to the County's current plan. The insurer is new to Leon County and their service area was recently approved (August 2004) by the Agency for Health Care Administration. United offers employers many plan options (Attachment #2). The plan design proposed to Leon County consists of an HMO and Point of Service (POS) plan. A POS plan is similar to a Preferred Provider Organization (PPO) in that both plans give the member the flexibility to access out of network benefits.

At the September 14, 2004 meeting, United presented a proposal requesting approval as a third provider of health insurance coverage for Leon County. The Board directed staff to review United's rate proposal and determine whether or not United should be included as a provider in addition to CHP and Vista.

Analysis:

At the time in which the September 14, 2004 agenda item was written, United Health Care submitted an initial proposal. The proposal required United to become the sole health care insurance provider for Leon County. Based on this proposal, United indicated they could potentially save Leon County approximately $1 million in health care coverage costs.

While the United cost proposal looks promising and the plan design appears to be comparable to what the County currently has, staff believes a major change of this magnitude, at this late date, would have a significant impact on the County's employees (Board and Constitutional). These impacts may include, but may not be limited to, the following:

- United has not fully established its physician and hospital network in Leon County. It is anticipated that the network will be completed by January 2005.
- Once the United network is fully established, a complete physician network analysis needs to be performed to determine which physicians will or will not be available as compared to the County's current providers (CHP and Vista). In addition, based on this analysis, an assessment will need to be made of the number of employees that will be required to select new medical providers.
- Thirty (30%) or approximately 440 employees of the County total participation base of 1467 employees are currently enrolled with staff doctors employed by CHP. These are not independent physicians, and accordingly, employees enrolled with CHP employed doctors will be required to select new providers within the United physician network.
- CHP informed staff that, currently, they have exclusive contracts with some independent medical providers which limit the acceptance of patients from only one HMO, namely CHP. Leon County needs to determine the impact of these contracts, who the providers are, and the number of employees impacted.
- Staff has not been given an opportunity to notify employees (Board and Constitutional) of any potential changes to a new health insurance coverage provider for the 2005 plan year.

Staff does not recommend United as a sole provider for the upcoming 2005 plan year. However, it is recommended that United be included in the County's Health Insurance Renewal negotiations process in preparation for the 2006 plan year.

Additional United Proposals

Since the initial proposal submitted by United and included in the September 14, 2004 agenda, United has submitted two additional proposals to Leon County. One additional proposal required that United become one of two health care providers for Leon County. This proposal required the elimination of either CHP or Vista as a health insurance provider. Staff does not recommend this option because of similar impacts, as outlined above, for a sole provider. The final proposal from United, received immediately prior to the start of the September 14, 2004 Board meeting, requested that United become an additional provider of health insurance coverage. Under this proposal, United would become the third provider of health insurance coverage for Leon County in addition to CHP and Vista.

Third Provider Analysis

United has submitted a rate proposal as a third provider of health insurance coverage for Leon County (Attachment #3). United's rates are based on an enrollment of approximately 20% of the current participation base of 1467 employees. In the following table, monthly rates for United have been compared to those of CHP and Vista: (Please note that rates shown were provided by CHP and Vista prior to United's proposals as a third provider of health insurance coverage for the County).

Table #1
Comparison of 2005 Proposed Monthly Rates/Enrollment Levels
United, CHP and Vista

	United *	CHP**	Vista**
Single	$ 373.96	$ 392.50	$ 407.64
Employee +1	774.10	812.50	843.74
Family	990.99	1040.20	1080.10
Current 2004 Enrollment Levels	0	1202	265
Proposed 2005 Enrollment Levels	293	962	212
Enrollee %/ # Inc/(Dec.)	20%/ 293	(20%)/ (240)	(20%)/ (53)

*Enrollment numbers based on United Health Care projections of 20% employee transfers from CHP and Vista.
**Rates shown are contingent upon CHP and Vista participation with a third provider and originally proposed rates remaining the same.

As reflected in Table #1, United's overall rate structure, as a third provider, is approximately 4.7% lower than CHP and 9% lower than Vista. However, these rate differences are not guaranteed into the future for any of the providers. Based upon United being added as a third provider, Table #2 below provides a comparison of annual cost by provider (with and without United), estimated gain/loss to each provider and potential cost savings to Leon County with the addition of United as a third provider.

Table #2
Comparison of Annual Cost
Potential Provider Gain / (Loss)
County Savings

	United *	CHP**	Vista**	Total
Annual Cost with Current providers (CHP and Vista)		$ 11,225,840	$ 2,403,058	$ 13,625,898
Annual Cost with United as a Third Provider	$ 2,576,102	$ 8,978,272	$ 1, 922,446	$ 13,476,820
Potential Provider Gain/(Loss)	$ 2,576,102	($ 2,247,568)	($ 480,612)	**$ 149,078 County Savings**

*Annual Cost estimates based on United projected enrollment of 20% of current participation.
** Estimates shown are contingent upon CHP and Vista participation with a third provider and originally proposed rates remaining the same.

As reflected in Table #2, if United is included as a third provider of health insurance coverage for Leon County, the County could potentially save approximately $150,000. However, this is contingent upon United meeting its projected enrollment numbers of 20% or approximately 300 employees. Additionally, CHP and Vista could potentially lose 20% of its current participation base for a combined loss of $2.5 million.

The plan designs for United, CHP and Vista are very comparable to the County's current plan design. Attachment #4 provides a side-by-side comparison of the plan designs and the differences in each. Also, attached is the 2003 AHCA HMO Report Card for Florida, which includes United, CHP and Vista (Attachment #5).

Contribution Strategies (Board Only)

As in years past, Leon County will continue to equalize the employee contribution for each plan offered. Staff recommends that the employee's percentage contribution requirement be applied to the CHP premiums to determine the rate to be paid, since approximately 82% of the workforce has currently elected CHP for their health plan.

Responses from CHP and Vista,

CHP and Vista have submitted written responses as to whether or not they will participate as one of three providers for Leon County (Attachment #6). CHP's response indicates that they cannot agree to be offered as one of three carriers for County employees due to the potential for adverse selection and instability of the risk pool. Vista's response indicates that they will participate as one of three providers. Based on the response from CHP, staff recommends that the Board not include United Health Plan as a third provider in the 2005 plan year. However, staff does recommend that a workshop is held early in the 2005 calendar year to discuss all possible options for health insurance coverage in Leon county prior to the next renewal period.

Options:

1. Approve the renewal rates reflected in Alternative #1 (Attachment #1Current HMO Plan) for the new plan year (January 2005 through December 31, 2005) for CHP and Vista as the only health insurance coverage providers and schedule a Board workshop in early 2005 to discuss all options for health insurance coverage for Leon County.

2. Approve the renewal rates reflected in Alternative#1(Attachment #1Current HMO Plan) for the new plan year (January 2005 through December 31, 2005) for CHP, Vista and include United Health Care as a third provider of health insurance coverage for Leon County (CHP will not participate as one of three providers).

3. Direct staff to include United Health Care in negotiations for the 2006 plan year for County Health Insurance Coverage.

4. Approve the renewal rates reflected in Alternative #2 (Attachment #1Current HMO Plan – Increased Prescription Co-pays) for the new plan year (January 1, 2005 through December 31, 2005).

5. Approve the renewal rates reflected in Alternative #3 (Attachment #1(New Plan P – Increased Co-Pays Prescriptions and Services) for the new plan year (January 1, 2005 through December 31, 2005).

6. Board Direction.

Recommendation:

Option #1.

Attachments:
1. Agenda Item – September 14, 2004 Board meeting
2. United Health Care Company Background
3. United Health Care Rate Proposal
4. Plan Design Comparisons, United, CHP and Vista
5. AHCA 2003 HMO Report Card for Florida
6. Responses from CHP and Vista on Participation

cc RM ve.

Board of County Commissioners
Agenda Request

Date of Meeting: September 14, 2004

Date Submitted: September 8, 2004

To: Honorable Chairman and Members of the Board

From: Parwez Alam, County Administrator
Lillian Bennett, Director of Human Resources

Subject: Renewal of Health Insurance Coverage for the 2005 Plan Year

Statement of Issue:

This agenda item requests Board approval of the renewal rates and consideration of renewal options for the two group health insurance providers, Capital Health Plan (CHP) and Vista (formerly Health Plan Southeast) for the January 1, 2005 through December 31, 2005 plan year.

Background:

County health insurance costs have continued to rise in recent years. For plan year 2004, the cost of County health insurance increased by 16% for a total cost of $11.9 million. For plan year 2003, the County experienced an increase of 17%. In spite of these increases, the Board has consistently and generously rewarded employees by maintaining an employee/employer contribution ratio structure of 7.5% and 92.5%, respectively for payment of health insurance premiums. It is important to note that all Constitutional Offices and Retirees also participate in these health plans.

Current health insurance monthly costs and the distribution of those costs between employees and the County are included in Table #1 below.

Table #1
CURRENT MONTHLY HEALTH INSURANCE COSTS
7.5% EMPLOYEE/ 92.5% COUNTY CONTRIBUTION
(7.5% as applied to CHP premiums and applied to Vista plans)

PROVIDER/COVERAGE	EMPLOYEE	COUNTY	TOTAL
CHP - Single	$ 25.66	$ 316.14	$ 342.00
CHP - EE + 1	53.10	654.90	708.00
CHP - Family	67.98	838.42	906.40
Vista - Single	25.66	342.30	367.96
Vista- EE + 1	53.10	708.51	761.61
Vista - Family	67.98	906.98	974.96

Analysis:

Health Insurance Renewal Rates and Renewal Alternatives

In review of health insurance industry trends staff reviewed articles published by leading insurance industry consulting firms regarding health care cost, plan designs and contribution strategies. These consulting firms determined the rate increases for HMO's would be between 10% and 14% for 2005. Additionally, to reduce cost, companies have increased the co-pays and shifted more burdens upon the employee in cost sharing (Attachment #1). In preparing the 2004-2005 budget, staff anticipated a 15% increase for health insurance premiums. County-wide costs for the current plan year 2004 (Board and all Constitutional Offices) are estimated to be approximately $11,948,376.

For the 2005 plan year, staff has prepared three (3) alternatives for Board review and consideration. These alternatives are summarized in Table #2 below and are based on current participation levels.

Alternative #1 - This option reflects the Boards current HMO plan structure. There are no changes to the current plan designs for this year. This option would increase overall health insurance premium costs to approximately $13,625,898 (approximately 14%).

Alternative #2 – This option reflects the Boards current HMO plan structure with changes only in the prescription co-pay amounts as follows:

Increase prescription co-pays from:

- CHP - $7.00 generic, $20.00 preferred, $35.00 non-preferred to $10, $25, $40 respectively
- Vista - $7.00 generic, $14.00 preferred $30.00 non-preferred to $10, $25, $40 respectively

With the reduction of benefits, more cost is shifted to the member; therefore, both plans can offer a reduced premium. This option would increase overall health insurance premium costs to $13,367,320 (approximately 12%), resulting in a savings of $258,000 over Alternative #1.

Alternative # 3- CHP and Vista also presented Plan P as an alternative. Plan P reduced our current benefits significantly more than Alternatives #1 and #2. Plan P increased copays on prescriptions and certain provided services by $5 to $15, and included a $250 copay for each hospital stay, each in-patient mental health stay and each maternity stay. A summary of the differences in Plan P and the current plan is shown in Attachment #2. Plan P would increase overall health insurance premium cost to $12,868,250 (approximately 8%), resulting in a savings of $757,648 over Alternative #1 and a savings of $499,070 over Alternative #2. Staff has prepared a more detailed 2005 Health Insurance Renewal Comparison as shown in Attachment #3.

In addition, Plan P is similar to the Plan M selected last year by the State of Florida. The State of Florida's 2005 rates are currently being negotiated; however, the 2004 employee premium cost for family coverage is approximately $175.96 per month, the City of Tallahassee 2005 proposed employee premium cost for family coverage is $300.70 per month and the Leon County School Board's 2005 employee premium cost for family coverage is $428.29 per month (ten month rates). The County's 2005 proposed employee cost for family coverage is $78.02 per month.

Table #2

Alternate Plan Offerings and Approximate Costs (based on current enrollments)

Alt	Desc. Summary	Benefits Change Summary [1]	Monthly Rates Current & Proposed and Increase (Inc.) Over Current				Estimated Total Costs
			Plan	Single	EE + 1	Family	
Current Monthly Rates/Employee (or Retiree)			CHP Vista	342.00 367.96	708.00 761.61	906.40 974.96	$11,948,376
#1	Current HMO plan structure	CHP's drug co-pay of $7-generic, $20 preferred on formulary, $35-others. Vista $7 generic, $14 pref., $30 others. Both have $10 PCP co-pay.	CHP Inc. Vista Inc.	392.00 +50.50 407.64 +39.68	812.50 +104.50 843.74 +82.13	1,040.20 +133.80 1,080.10 +105.14	$13,625,898 14% inc.
#2	Current HMO plan structure	CHP & Vista co-pays for Rx increase $10-generic,$25 preferred on formulary $40 others.	CHP Inc. Vista Inc.	386.40 +44.40 393.28 +25.32	799.90 +91.90 814.01 +52.40	1,024.10 +117.70 1,042.04 +67.08	$13,367,320 12% inc.
#3	New Plan P	CHP and Visa co-pays for RX increase as in Alt#2, provider services increase, $250 co-pay for hospital, mental health and maternity stays	CHP Inc. Vista Inc	374.30 +32.30 385.80 +17.84	744.80 +36.80 798.54 +36.93	991.40 +85.50 1,022.23 +47.27	$12,868,250 8% inc.
For more detailed benefit comparison, see Attachment #3.							

The County received a preliminary proposal from United Health Care (United) as another alternative to the County's current plan. The insurer is new to Leon County and their service area was recently approved (August 2004) by the Agency for Health Care Administration. United offers employers many plan options. The plan design proposed to Leon County consists of an HMO and Point of Service (POS) plan. A POS plan is similar to a Preferred Provider Organization (PPO) in that both plans give the member the flexibility to access out of network benefits. United Health Care requires that they become the sole health care insurance provider for the County.

At this time, Tallahassee Memorial Hospital is the only contracted hospital with United; however, United is currently conducting negotiations with Capital Regional Medical Center and other physician groups in the area to become a part of their contracted network of providers. United anticipates completing their provider network by January 2005. In considering United for this year, staff took into account the cost of the plan, the plan design, and the contracted hospitals and physician's network currently available. In addition, staff is aware that more than 30% of Leon County employees (Board and Constitutional) currently use a CHP staff doctor which may be problematic when changing to United. These employees may be required to change to an in-network provider.

United Health Care looks very promising and will bring some needed competition into the health care negotiations process. Staff recommends that the County seriously consider United in negotiations next year, once their hospital and physician networks are complete, and when staff can determine with certainty the impact on Leon County employees who currently utilize CHP staff doctors.

Contribution Strategies (Board Only)

As in years past, Leon County will equalize the employee contribution for each plan offered. Staff recommends that the employee's percentage contribution requirement be applied to the CHP premiums to determine the rate to be paid. This is due to the fact that approximately 82% of the workforce has elected CHP for their health plan and to do otherwise would result in 82% of the workforce paying less than the percentage contribution determined by the Board. However, this recommendation results in Vista members paying a slightly lower percentage of the premium costs for their plan (as Vista's premiums are higher than CHP's).

Options:

1. Approve the renewal rates reflected in Alternative #1(Current HMO Plan) for the new plan year (January 2005 through December 31, 2005).

2. Direct staff to include United Health Care in negotiations for the 2006 plan year for County Health Insurance Coverage.

3. Approve the renewal rates reflected in Alternative #2 (Current HMO Plan – Increased Prescription Co-pays) for the new plan year (January 1, 2005 through December 31, 2005).

4. Approve the renewal rates reflected in Alternative #3 (New Plan P – Increased Co-Pays Prescriptions and Services) for the new plan year (January 1, 2005 through December 31, 2005).

5. Board Direction.

Recommendation:

Options #1 and #2.

Attachments:
1. Health Insurance Industry Articles
2. Plan P Differences from Current Plan
3. 2005 Health Insurance Renewal Comparison

Press release:

New Hay Group Study Finds that Medical Premiums Continue Double-Digit Rise for Fifth Consecutive Year

Issued by: Hay Group

Date: Wednesday, August 18, 2004

Employers see their fifth year of double-digit medical premium increases with an average increase of 10.5% in 2004. This is down from 2003, but still 3 times the inflation rate, with increases around 10% expected for 2005. Hay Group outlines prevalent cost containment strategies.

PHILADELPHIA, August 18, 2004: Medical premiums rose an average 10.5% in 2004 after plan reductions, according to the 2004 Hay Benefits Report, a cross-industry survey of over 1000 US companies. Although down from an average increase of 14% for 2003, the 2004 increase of 10.5% is sharply higher than the US Consumer Price Index of 3.3%. To make matters worse, medical premiums are expected to increase by about 10% again for 2005.

Stated in terms of payroll, employer costs for health benefits have risen steadily over the past four years from 7.28% in 2000 to 7.84% in 2002, and to 8.75% in 2004. Companies not able to absorb the medical cost increase this year or next would have to reduce medical benefits, reduce salary increases, reduce staff, or lower some other costs.

HMO and Point of Service (POS) plans, which require Primary Care Physician referrals for specialist visits and tests, have lower premium costs than Preferred Provider Organization (PPO) plans, which have no such requirement. Historically, HMO and POS plans have had lower cost increases due to the cost containment inherent in these required referrals. This pattern did not hold true for 2004. HMO premiums increased 14.75% and POS plan premiums increased 13.25% compared to 9.0% for PPO plans. This is probably due to HMO and POS plans easing up on approving referrals in response to litigation and consumer and government pressures.

EXPLORING CAUSES FOR CONTINUING RISING MEDICAL PREMIUMS' COSTS

Medical costs have been rising for a number of reasons. One reason is that reimbursement

rates to hospitals and physicians are on the rise. In the second half of the 1990s, HMO and PPO plans held down reimbursement rates to the point where healthcare providers took action to gain increases. For example, hospitals have been merging into larger systems, sometimes with physician networks, giving them more bargaining power in their negotiations with insurers.

Another cause of rising medical costs is continuously improving medical technology, which allows very sick people to live longer, and incur significant medical expenses. Prescription drug costs increasing at a rate exceeding 15% are another cause of rising medical expenses. Other factors include the aging of the workforce and the fact that Americans have become increasingly less healthy, especially in the areas of weight, diabetes, and heart disease.

"This is a very difficult time for companies to cope with double-digit medical premium rate increases," says Michael Carter, Vice President in Hay Group's benefits practice. "In the current business environment, most companies simply cannot afford to pass these costs along to their customers." As a result, to maintain current levels of profitability, companies are likely faced with shifting medical costs to employees, exploring new strategies to contain rising medical costs, as well as cutting costs in other areas.

"There is no one 'silver bullet' solution to contain medical costs, so companies must use multiple strategies," says Hay Group's Carter. He adds that "the longer companies wait to address the issue, the more painful it could be for them or their employees."

EMPLOYEES FACE INCREASED COSTS

One strategy is to shift more costs to employees. Many companies pay a fixed percentage of the premium, so when average premiums rise 10%, then employees' costs rise 10%. In addition, companies have been increasing employee deductibles, co-payments, and the limit at which employees' "out-of-pocket" expenses are capped.

One of the most striking changes in the last two years has been the increase in employee co-payments for doctor visits, with the number of plans with co-pays of $15 or more rising from 47% in 2002 to 72% in 2004. Moreover, 30% have co-pays of $20 or more in 2004.

Companies have also taken several actions in response to large increases in prescription drug costs. A common approach is to raise employees' co-payments. The typical co-pay for generic drugs doubled in the last two years from $5 to $10. Most of prescription plans now use a "formulary," a list of preferred lower-cost brand drugs with lower-dollar co-pays for employees than non-formulary brand drugs. The typical formulary co-pay is $20 in 2004, up from $10 two years ago, while the median non-formulary co-pay is $30 up from $15 two years ago.

In addition, one third of companies now require the use of lower-cost generic drugs if available, unless otherwise specified by the physician. The use of mail-order drugs for "maintenance" medication is also increasing in popularity (10% in 2004), as is the change from a fixed-dollar to a percentage-based co-payment (11% in 2004). This provides employees with more incentives to use generic and formulary drugs, and shifts part of drug cost increases to the employee.

Historically, companies have provided "wellness" programs that include preventive exams, health programs such as smoking cessation, and health club membership, all aimed at improving employees' general health. Companies also have offered "case management" programs aimed at controlling costs of major illnesses.

Disease Management focuses on improving the health—and thus controlling the costs—of common manageable diseases. These include diabetes, asthma, congestive heart failure, coronary artery disease, and hypertension. These voluntary programs, now in place in most companies, are designed to prevent the state of the disease from advancing, and where possible, to result in an improvement.

Health Reimbursement Accounts (HRA) and Health Savings Accounts (HSA) along with "high deductible" plans are also emerging as a cost containment strategy. These new types of plans involve a company-funded HRA or employee or company-funded HSA that employees can use for IRS-approved health expenses—including some items not typically covered in medical plans. Unused amounts can be carried over to the following year, in theory encouraging employees to become better health care consumers. Supplementing the HRA/HSA is a "high-deductible" plan, with typical annual deductibles ranging from $1000 to $3000 per individual.

Eleven percent of companies report offering as an option an HRA, high-deductible plan, or both. Typical employee participation in these options is reported at less than 10%. New in 2004, less than 10% of companies are expected to adopt HSAs for 2005.

WHAT COMPANIES ARE DOING

In addition to the strategies described above, one strategy used by our clients is that of "employee consumerism." This involves communicating to employees how medical cost increases affect them (e.g., higher employee costs, lower pay increases, lower staffing levels) and what they can do about it (e.g., improve health, use Disease Management, use 24-hour medical assistance services, ask questions of your provider, check insurer charges). "Employee consumerism enables clients to enlist their employees in the battle to control health care costs," says Carter.

Other strategies used by Hay Group's clients include negotiating rate renewals, bidding out coverage, consolidating plans and funding methods, and (to a lesser extent) implementing "consumer driven" plans like HRAs with high-deductible plans.

WHAT'S IN STORE FOR 2005?

Looking ahead to plan changes for 2005, more cost shifting is likely. However, Hay Group's Carter cautions that "there is a limit to the amount that companies can shift costs to employees, particularly lower-paid employees." With the average annual employee premium contribution for family coverage reaching $2400 in 2004 and increasing co-payments, companies will need to rely on strategies other than cost shifting. "Disease Management, which lowers costs by improving employees' health, currently is the best long-term strategy for controlling costs," says Carter.

ABOUT THE HAY BENEFITS REPORT AND HAY GROUP

Published annually for over 30 years, the Hay Benefits Report (HBR) contains extensive information about the design, cost, and trends of employee benefit plans, executive perquisites, and benefit-related personnel policies. Over 1000 organizations participated in the 2004 HBR, representing all industries and regions of the US.

Hay Group is a professional services firm that helps organizations worldwide get the most from their people by creating clarity, capability, and commitment. Founded in 1943 in Philadelphia, today Hay has 73 offices in 39 countries whose areas of expertise include: compensation, benefits, and performance management; executive remuneration; organizational effectiveness, role clarity, and work design; managerial and executive assessment, selection, and development; and customer and employee attitudes and behaviors.

An expertise-driven firm, all Hay Group's work is supported by proven methodologies and global knowledge databases and is based on over 60 years of specific, documented evidence that people, not strategies, drive long-term competitive advantage. (www.haygroup.com)

# # #

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June 3, 2004

HMO Rates Continue Double-Digit Increases, But Begin To Moderate

Hewitt Data Shows U.S. Employers Remain Aggressive in Managing Costs Through Plan Design Changes and Higher Cost Sharing

LINCOLNSHIRE, Ill. – Preliminary 2005 HMO rates will increase almost 14 percent, continuing a trend of double-digit health care cost increases, but are showing signs of moderation, according to new data from Hewitt Associates (NYSE: HEW), a global HR outsourcing and consulting firm.

As U.S. companies begin to negotiate health plan rates for 2005, data from the Hewitt Health Resource™ (HHR) – a Web site that captures HMO rate information for nearly 160 large employers representing more than 1 million employees and annual premiums of nearly $4 billion – shows that initial HMO rate increases are averaging 13.7 percent[1] compared to 17.5 percent at the same time last year. After plan changes, negotiations and terminations, the average HMO premium increased by 13.0 percent in 2004 (see charts for regional data).

"As we predicted last year, we're starting to see a moderation in health care premium increases, with the possibility of employers who aggressively manage their health care spending seeing increases in the single digits for the first time in five years," said Ken Sperling, East market leader for Hewitt's Health Management Practice. "The declining growth in HMO rates

reflects the fact that health plans have reached comfortable margins and are willing to price closer to their underlying costs."

2004 Summary

Despite cost moderation, companies are still facing double-digit increases and, as a result, continue to make plan design changes and share more of the cost with employees. For example, the number of companies offering a $20 office copay nearly doubled from 9 percent in 2003 to 16 percent in 2004. The number of organizations with a $15 office copay continues to increase in prevalence from 24 percent in 2002 to 47 percent in 2004. At the same time, employers offering $10 office copays continues to drop from 58 percent in 2002 to 29 percent in 2004.

"The work done by employers in past years is beginning to pay off in 2005," added Sperling. "The trend in health care cost increases has moderated due to stable hospital utilization rates, changes in prescription drug usage brought on by generic and over-the-counter alternatives, the positive impact of increased employee cost sharing on utilization rates, and an increased focus on disease management programs by employers."

Employees are also being asked to share more of the cost of prescription drugs (see chart below).

Percentage of Companies Offering Various Prescription Drug Options

Prescription Drug	2001	2002	2003	2004
Generic				
$5 co-pay	52%	46%	29%	28%
$10 co-pay	27%	40%	52%	50%
$15 co-pay			>1%	5%
Brand Formulary				
$10 co-pay	39%	28%	15%	12%
$15 co-pay	20%	30%	26%	20%
$20 co-pay	12%	26%	32%	33%
$30 co-pay			>1%	6%

Brand Non-Formulary				
$10 co-pay	13%	9%	7%	5%
$25 co-pay	16%	21%	8%	5%
$30 co-pay	11%	22%	19%	14%
>$30 co-pay	9%	24%	24%	38%
Drug Copayment Design				
1 tier	24%	15%	12%	12%
2 tier	32%	30%	24%	31%
3 tier	44%	55%	52%	49%

Specialty care office visit copays also continue to rise, with 35 percent of companies using a $15 copay, down from 40 percent in 2003, and 19 percent of companies are using a $20 copay, up from 12 percent in 2003. Sixteen percent of employers are introducing copays above $20. More than half (55 percent) of organizations currently use a $50 copay for emergency room visits, and 33 percent use a copay of more than $50, a significant increase from 16 percent in 2003 and only 7 percent in 2001.

"While this moderation in increases is good news for employers and employees, it's important to point out that employers and employees have endured years of double-digit increases, and health care continues to impact both corporate and individual pocketbooks," said Sperling. "Therefore, we expect companies to continue pursuing strategies that allow consumers to better manage their health and make smart choices about the health care services they consume."

About Hewitt Health Resource

Hewitt Health Resource is a Web-based service that helps companies manage all of their health plan interactions and data needs. HHR includes online capabilities for health plan selection and renewal, and Hewitt's Connections™ service for eligibility and premium management. To date, Hewitt has used HHR for 160 employers representing more than 1 million participants and nearly $4 billion in premiums. More than 120 health plans have also used the site.

Plan "P" Differences

Description of Benefit	2005 Renewal Plan	2005 Proposed Plan P
Plan Type	Plan F	Plan P
Physician Services		
Office Visit (during regular hours)	$10.00	$15.00
Office Visit (After regular hours)	$15.00	$20.00
Specialty Visit w/ PCP Referral	$10.00	$25.00
Outpatient Surgical Care	$10.00	$25.00
Mental Health outpatient care (20 Visits)	$20.00	$25.00
Hospital Services		
Hospital benefits covered	$0.00	$250 per admission
Outpatient Surgical Procedures	$0.00	$0.00
Mental Health Inpatient Care	$0, (Max 31 Days)	$250 per admission (31days)
Maternity Services		
Physician Services		
Office Visit w/ PCP	$10.00	$15.00
Specialty Visit w/ PCP referral	$10.00	$25.00
Hospital Services		
All Maternity Inpatient Care	$0.00	$250 per admission
Urgent Care Services	$15.00	$20.00
Visits for short-term physical/speech	$10.00	$25.00
Routine eye exams for vision correction	$10.00	$15.00
Out Patient Services		
Cat Scan , MRI, etc.	$0.00	$100.00
Maximum amt. Co-pay for 1 calendar yr.	$1,500.00 (Per Member) $3,000.00 (Per Family)	$2,000.00 (Per Member) $4,500.00 (*Per Family-Excludes Prescription Drug Copays*)

Attachment # 4
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2005 HEALTH INSURANCE RENEWAL COMPARISON

2005 Health Insurance Renewal Benefit Comparison

Description of Benefit	2005 Renewal CHP Plan	(1)	2005 Proposed CHP Plan (2)	2005 Current Alternate	(1)	2005 Proposed Alternate (2)
Plan Type	Plan F	Plan F	Plan P	Plan 1427	Plan 1427	Plan P
Physician Services						
Office Visit (during regular hours)	$10.00	$10.00	$15.00	$10.00	$10.00	$15.00
Office Visit (After regular hours)	$15.00	$15.00	$20.00	$10.00	$10.00	$15.00
Specialty Visit w/ PCP Referral	$10.00	$10.00	$25.00	$10.00	$10.00	$25.00
Outpatient Surgical Care	$10.00	$10.00	$25.00	$10.00	$10.00	$15
Mental Health outpatient care (20 Visits)	$20.00	$20.00	$25.00	$20.00	$20.00	$25 (30 visits)
Hospital Services						
Hospital Benefits covered	$0.00	$0.00	$250 per admission	$0.00	$0.00	$250 per admission
Outpatient Surgical Procedures	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mental Health Inpatient Care	$0, (Max 31 Days)	$0, (Max 31 Days)	$250 per admission (31days)	$0, (Max 30 Days)	$0, (Max 30 Days)	$250/adm, (Max 30 Days)
Maternity Services						
Physician Services						
Office Visit w/ PCP	$10.00	$10.00	$15.00	$10.00	$10.00	$15.00
Specialty Visit w/ PCP referral	$10.00	$10.00	$25.00	$10.00	$10.00	one time $25.00
Hospital Services						
All Maternity Inpatient Care	$0.00	$0.00	$250 per admission	$0.00	$0.00	$250 per admission
Emergency Services						
Emergency room visits	$100 per episode	$100 per episode	$100 per episode	$50 waived if admitted	$50 waived if admitted	$100 per episode waived if admitted
Emergency services outside area	$100 per episode	$100 per episode	$100 per episode	$50 waived if admitted	$50 waived if admitted	$100 per episode waived if admitted
Urgent Care Services	$15.00	$15.00	$20.00	$10.00	$10.00	$20.00
Other Benefits						
Home Health Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Home Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Outpatient Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Inpatient Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Skilled nursing facility for up to 60 days per admission	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Durable medical equipment and prosthetic medical appliances	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Alcohol and Drug ABuse	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Detox Only-Combined with Mental Health Benefits	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY
Outpatient prescription drugs	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY
Visits for short-term physical/speech or other rehabilitation therapies	$10.00	$10.00	$25.00	$10.00	$10.00	$25.00
Routine eye exams for vision correction	$10.00	$10.00	$15.00	$15.00	$15.00	$15.00
Exclusions						
Maximum amt. Co-pay for 1 calendar yr.	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$2,000.00 (Per Member) $4,500.00 (Per Family-Excludes Prescription Drug Copays)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$2,000.00 (Per Member) $4,500.00 (Per Family-Excludes Prescription Drug Copays)
				mail order (3) copay 90 day supply	mail order (3) copay 90 day supply	mail order (3) copay 90 day supply
Prescription Drug Benefit						
Generic Drugs	$7.00	$10.00	$10.00	$7.00	$10.00	$10.00
Preferred Brand Drugs	$20.00	$25.00	$25.00	$14.00	$25.00	$25.00
Non-Preferred Brand Drugs	$35.00	$40.00	$40.00	$30.00	$40.00	$40.00
Other Rates						
Employee	$392.50	$366.40	$374.30	$407.04	$393.28	$385.80
Employee + 1	$812.50	$799.90	$744.80	$843.74	$814.01	$798.54
Family	$1,040.20	$1,024.10	$991.90	$1,080.10	$1,042.04	$1,022.23

INNOVATIVE SOLUTIONS TO HEALTH CARE AFFORDABILITY

At UnitedHealthcare we understand that the majority of our public sector and municipal customers are facing the same challenge: rising healthcare costs and shrinking budgets available to fund their health benefit programs. According to the Merrill Lynch 2003 Managed Care Industry Reference Guide, "Over the last few years, costs have risen at what seems on its face to be an unsustainable rate. Health care cost increases have ranged in the 8-12% range annually, levels at which health costs wind up doubling every 6-9 years. Cost increases have been driven by growth in pharmacy and outpatient services and, to a lesser extent, inpatient care." This type of growth in medical costs puts an even heavier burden on public sector entities that are often limited by:

- Budget allocations that are limited and pre-determined by legislation.
- Limited ability to change benefits due to union agreements or legislative requirements.
- Inability to pass costs on to enrollees due to previous benefit changes, union agreements or legislative requirements.

Customers can no longer afford to select their health care administrator solely for their ability to manage a network, administer claims and customer service and conduct care management or to stay with the status quo. Health care administrators must do all of that expertly and more – they need to be developing new approaches to controlling costs.

At UnitedHealthcare we have been doing just that. We are not reacting to the marketplace, but driving change in the system that improves affordability and quality. We can offer the State of Florida a multi-disciplined approach to controlling costs that includes:

- A Dedicated Business Focus to Floridians
- A Dedicated Business Focus on Public Sector Customers
- New Products
- Network Management Focused on Providing Choice, Managing Cost and Driving Quality
- An Innovative Approach to Care Management using Technology and Predictive Modeling Focused on Improved Outcomes
- Industry-leading Evidence-Based Approached to Care Through Our New Centers of Excellence Program
- Integrated Pharmacy and Medical data allowing for seamless interaction and analytics
- "Best in Class" Data and Employer Tools to Manipulate, Analyze and Apply Data
- Consumerism: Strategies and Tools to Assist Employees in Making the Best Medical Treatment Decisions
- Underwriting Support for Plan Design Analysis and Relativity Factors

We are including information for your review detailing our efforts in each of these areas that demonstrate the various ways in which we can support you in revising your health care benefit plan to more effectively spend your health care dollars and ultimately put into action a plan that will help the State of Florida stem its rising costs.

A DEDICATED BUSINESS FOCUS TO FLORIDIANS

- 1.8 million Floridians covered by UHG products
- We employ nearly 2000 UnitedHealth Group employees in Florida
- We operate health plan offices in Jacksonville, Orlando, Miami, Sunrise, Tampa, and Tallahassee
- We offer broad provider networks with more than 19,800 physicians and 210 hospitals
- We serve Floridians through many programs including:
  - UnitedHealthcare Health Coverage
  - Ovations Medicare + Choice and Medicare Select PPO
  - AARP
  - Evercare - Frail Elderly
  - Healthy Kids
  - Health and Home
  - Americhoice Medicaid
  - Spectera - Vision Services
  - Dental Benefit Providers

DEDICATED BUSINESS FOCUS: PUBLIC SECTOR AND MUNICIPAL EMPLOYERS

We understand that public sector and municipal customers have unique needs and special requirements. That's why UnitedHealthcare created a separate business segment solely dedicated to public sector and municipal customers. The business segment is comprised of its own President, sales team, local account managers and internal support personnel. Through a dedicated business segment we are able to provide clear focus and accountability to our customers in this market segment. Our commitment to our large public sector customers also includes access to UnitedHealthcare senior management.

Our experience and commitment to the public sector is demonstrated by the fact that we administer benefits to over 1,000,000 members in the public sector including:

AISD
Arlington Independent School District

Georgia Department of Community Health

Mecklenburg County, North Carolina

Fort Worth

New York State

UnitedHealthcare

We serve over 100 public sector customers in Florida. A sampling of our public sector customers in Florida includes:

Miami-Dade County Public Schools

MDCPS

Pinellas County

OrangeCountyFl

Polk County Board of County Commissioners

University of Miami

Escambia County School District

PUBLIC SECTOR EXPERIENCE EXAMPLE: UNITEDHEALTHCARE AND THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Division of Public Employee Health Benefits within the Georgia Department of Community Health is responsible for providing health insurance coverage to state employees, school system employees, retirees and their dependents. The Georgia Department of Community Health selected UnitedHealthcare to provide our Choice product as an option to employees beginning with the 2002-2003 plan year.

Since first being offered in 2002, UnitedHealthcare has doubled its membership among Georgia public employees and is growing at a rate of approximately 1,000 new members per month.

Date	Subscribers	Members
July 2002	5,942	13,645
July 2003	14,823	35,142
August 2003	14,882	35,180
September 2003	15,360	36,129
October 2003	16,096	37,403
October 22, 2003	16,704	38,100

WHAT IS DRIVING THE GROWTH?

- Product: UnitedHealthcare Choice
- Network Development

Product

UnitedHealthcare's Choice product is an open access product that offers easy access to physicians and specialists without referral. We have 20 years of experience in offering open access – UnitedHealthcare pioneered the concept of Open Access. We converted members from competitor HMOs to the UnitedHealthcare Choice HMO product:

- Many members reported frustration with other carrier's gatekeeper requirement.
- The UnitedHealthcare Choice product is open access and requires no referral to see a specialist.

Network Development

When we began our partnership with Georgia Department of Community Health, we committed to grow our network in the rural counties of Georgia where the state has large membership.

- During the last open enrollment period, we introduced UnitedHealthcare in 16 counties where we were previously not offered.
- In 9 of the 16 counties, we were the only HMO offered because other carriers have not pursued enhanced network access on behalf of the state.
- We are developing a network in five additional counties to address the network the state will lose through Beech Street so the state will not have to lose out on discounts by having those employees turn to non-network providers.

We have an ongoing partnership with the State of Georgia Department of Community Health to target and grow our network in areas where they need us the most. We will apply the same creativity and commitment to the State of Florida.

NEW PRODUCTS

Consumers are at the center of the products and services offered by UnitedHealthcare. We were the first to enable the consumer-physician relationship through Care Coordination and we remain the leader in providing decision tools to consumers most notably through the content and interactive experiences offered through our consumer portal, myuhc.com. In concert with the traditional health plan model, we use these tools to enable consumers to take greater control of the decisions impacting their health care understanding that with this expanded control over decisions generally comes additional financial responsibility.

We understand the State accepted the challenge of improving the current health care spend by $58 million which is a 7% improvement needed to keep the projected spend at $840 million for fiscal year 2004/2005. In considering the recommended plan design changes, which is the most common remedy considered by most employers in response to rising health care costs, we believe that 6% savings is achievable based on the presented benefit adjustments. Without actual experience, however, we cannot incorporate the impact of the network saving which we believe is superior to the State's current experience. The State's cost improvement plan can be further enhanced by our care model which we can demonstrate is a more effective approach to managing care, identifying gaps in care before a catastrophic even occurs, teaching consumers how to take better care of themselves as well as making more informed health care choices.

We have taken the liberty of providing an additional plan design that could supplant the base plan in the proposed bundles. By using more aggressive cost sharing on the front end through a larger deductible, adding higher copayments to pharmacy and more per occurrence cost sharing on facility services and specific diagnostic services which tend to be over prescribed: MRIs, Nuclear Medicine, CT Scans and PET Scans, we believe the State can further enhance its cost saving potential by 2% to 3% based on the value of the benefits. This plan compares less favorably to the proposed base plan from the enrollee's perspective, but still offers adequate coverage in exchange for a smaller payroll contribution. The other two plans can be offered alongside this recommendation for employees less tolerant of financial consequence at the point of care. By broadening the gap between the plans, we believe the State can achieve a more desirable shift in plan enrollment and can allocate contribution amounts accordingly. With an aging population and the continued advancement in technology and pharmaceuticals, we believe it is desirable for the State to consider a plan that provides options to cushion the baseline savings objective.

We suggest continuing the strategy in subsequent years but modify the core plan such that is compliant as a High Deductible Health Plan (HDHP) as defined in the recently passed Medicare/HSA legislation. The cost sharing increases substantially, but a much lower cost product results permitting employees to redirect some of their payroll dollars that would have otherwise been used to subsidize a higher contribution level into a tax-advantaged investment account. The HSA feature is suggested because it is the first time in the history of the U.S. tax code that individuals can put money in an account on a pre-tax basis, earn interest and take the money out tax-free to pay for qualified medical expenses. There is not a "use or lose it" provision and there are no cumbersome requirements like mailing in receipts or claim forms. It is reasonable to expect employees to be more receptive to cost sharing changes when a portion of the savings are passed on to them and there is a way to set all or part of those dollars aside to pay for future health care expense on a tax-free basis.

There are also ad hoc options from which the State can choose to further enhance its ability to control health care spending.

- Shared Pharmacy combines the convenience of a copayment with the savings of a scheduled benefit. The consumer pays a flat copayment ($10/$25/$40) just like they do today, but UnitedHealthcare or the plan, pays only up to a fixed amount per prescription with the consumer paying the balance. Catastrophic protection is provided in the form of a stop loss limit. Such a program can result in additional pharmacy savings of 15% to 20% over the current 2004 pharmacy program

- Maximum Non-Network Reimbursement (MNRP) is a program pioneered by UnitedHealthcare to help employers save on non-network costs. By paying a fair reimbursement to non-network providers at the 110th percentile of Medicare RBRVS or DRG, non–network costs are better controlled and we continue our ability to drive volume to our network providers preserving our unit cost advantage. The value of MNRP is difficult to assess from a benefit standpoint as it is directly related to non-network utilization, which is difficult to evaluate without actual experience. Based on the experience of existing client base, however, we believe that this option possesses the ability for the State achieve incremental savings above the initial goal.

UnitedHealthcare is uniquely positioned to offer the State a variety of product solutions to meet its financial objectives. We understand that change must be incremental moving at a pace acceptable to the State and its employees. It must be implemented in such a way that employees are offered fair trade-offs in exchange for out of pocket exposures they determine appropriate for their particular situation. Finally, it must be packaged in such a way that real value is achieved through excellent service levels and meaningful consumer experiences.

Leon County BCC

Effective Date: January 1, 2005

	Option #1
PLAN OFFERED	
Overture Package Name	N/A
Plan Name	NRA (1 C INS)
Overture Plan	N/A
Product	Choice *
Locations	Florida
Plan Offering	Single Option
Multiple Option with:	Option(s) N/A
i-Plan	No
RATES	
Employee	$373.96
Employee + 1	$774.10
Employee + Family	$990.99
ASSUMED ENROLLMENT	
Employee	442
Employee + 1	353
Employee + Family	619
Monthly Premium	**$1,051,972**
Annual Premium	**$12,623,663**
BENEFITS*	
In-Network:	
Office Copay (PCP/SPC)	$10 Per Visit
Other Copays (IP/ER/UC)	N/A/$75/$35
Deductible (Individual/Family)	N/A
Coinsurance	100%
Out-of-Pocket (Individual/Family)	N/A
Pharmacy	$7/25/40
Out of Network:	
Deductible	N/A
Coinsurance	N/A
Out of Pocket	N/A

*Rates based on 20% of these Enrollment Figures

*High level benefit summary. Please see your plan summary for more detailed benefit description.

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Leon County BCC
Effective Date: January 1, 2005

Medical Quote Assumptions

- Rates are guaranteed for 12 months for the contract period of 1/1/05 through 12/31/05.
- Rates assume a multiple carrier offering scenario.
- UnitedHealthcare reserves the right to adjust the rates if the enrollment at issue varies by +/- 10% from the submitted census.
- Employer contributes a minimum of 75% toward the employee only rates and 75% toward the dependent rates.
- Requires a minimum participation level of 75%.
- Quote is subject to final underwriting which may have conditions. Additional paperwork and/or information may be required.
- Preliminary rates are subject to an employer form approval process which may include a telephone interview.
- Quote assumes no out of area or retiree lives.
- Unless otherwise stated, this offer replaces and renders all previous offers null and void.
- Includes Deductible rollover from previous carrier, if applicable.

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LEON COUNTY BOARD OF COUNTY COMMISSIONERS

MEDICAL PLAN COVERAGE COMPARISON CHART - 2005

The following chart is a brief outline/summary of benefits of the medical plans offered at LCBCC. This summary is intended to just highlight the Plan benefits and does not constitute a contract. Complete benefit plan provisions are available in the master policies, contracts or agreements. If there are discrepancies between this summary and the policies, contracts or agreements, then the provisions of the policies, contracts and agreements will take precedence.

SUMMARY OF BENEFITS

COVERAGE	***HPSE/MSTA***	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE*** NRA - Choice 1C Plan
OUT-OF-POCKET MAXIMUM			
Individual	$1,500	$1,500	None
Family	$3,000	$3,000	None
LIFE TIME MAXIMUM	None	None	None
	MEMBER COPAY	***MEMBER COPAY***	***MEMBER COPAY***
PHYSICIAN SERVICES			
Inpatient Medical Visits	No Charge	No Charge	No Charge
Office Visits	$10/visit	$10/visit	$10/visit
Surgery	No Charge	$10 Copay in phyclans office No Charge when in Hospital	$10 Copay in phyclans office No Charge when in Hospital
Anesthesia	No Charge	No Charge	No Charge
Allergy Testing/Treatments	$25/test	$10 Copay	$10 Copay
Allergy Injections	$10/visit	$10 Copay in physicians office	$10 Copay in physicians office (No copay unless a physican charge is billed)
Maternity (Pre & Post Care)	$10/visit	$10/visit	$10/Initial visit only then 100%
Lab Work	No Charge	No Charge	No Charge
PREVENTIVE SERVICES	***HPSE/MSTA***	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE***
Routine Physicals	$10/visit	$10/visit	$10/visit
Immunizations/Screenings	$10/visit	$10/visit	$10/visit
Well Child Care	$10/visit	$10/visit	$10/visit
Hearing Screening	$10/visit	$10/visit up to age 17	$10/visit
DIRECT ACCESS SERVICES			***All Specialist Services-No Referral***
Dermatology	$10/visit; limit of 5 visits/year	$10/visit; limit of 5 visits/year	$10/visit
OB/GYN Exam	$10/visit; limit 1/contract year (requires no PCP referral) for breast/pelvic exam & pap smear (or as physician requested)	$10/visit for well woman exam	$10/visit
Vision Screening	$10/visit; limit 1/contract year (requires no PCP referral) for annual eye exam (or as physician	$10/visit for routine eye exams	$10/visit - once per year
/glasses & contact lenses not cove			

Podiatry	$10/visit; 1 time visit (additional treatment when authorized)	$10/visit; when medically necessary	$10/visit	
Spine & Back Disorder Treatment	$10/visit; subject to approved treatment plan	$10/visit; for acute & diagnostic conditions	$10/visit - 24 visits per year	
DIABETES TREATMENT				
In Physician Office	$10/visit	$10/visit; see member handbook for details	$10/visit	
Outpatient Diabetes Center	$25/year			
IN-HOSPITAL SERVICES				
Semi-Private Room & Board	No Charge	No Charge	No Charge	
Ancillary & Professional Services	No Charge	No Charge	No Charge	
Medical Services	No Charge	No Charge	No Charge	
Anesthesia	No Charge	No Charge	No Charge	
Maternity (Pre & Post Care)	No Charge	No Charge	No Charge	
IN-HOSPITAL SERVICES (continue	***HPSE/VISTA***	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE***	
Diagnostic Services	No Charge	No Charge	No Charge	
Intensive Coronary Care	No Charge	No Charge; when medically necessary	No Charge	
Surgical Procedures	No Charge; subject to approval	No Charge; subject to approval	No Charge	
Operating & Recovery Room	No Charge	No Charge	No Charge	
Acute & Chronic Dialysis	No Charge	No Charge	No Charge	
Drugs, Medications & Radiotherapy	No Charge	No Charge	No Charge	
Specialty Care & Consultants	No Charge	No Charge; when medically necessary	No Charge	
Special Duty Nursing	No Charge	No Charge; when medically necessary	No Charge	
OUTPATIENT HOSPITAL SERVICES				
Outpatient Surgery	No Charge	No Charge	No Charge	
Radiology & Diagnostic Testing				
Mammogram	No Charge	No Charge	No Charge	
Routine: Chest x-ray, EKG, etc	$10/test	No Charge	No Charge	
Specialized: Ultrasound, EEG, allergy testing, etc.	$25/test	No Charge; (see previous information on allergy t	No Charge	
Extensive: Cat scan, MRI, etc.	$100/test	No Charge; may require prior authorization		
Lab Work	No Charge	No Charge	No Charge	
Chemotherapy	No Charge	No Charge	No Charge	

Dialysis Services	No Charge	No Charge	No Charge
Short Term Therapy Occupational, Physical, Speech, Inhalation	$10/visit; limit of 24 visits for an acute conditio	$10/visit; for conditions subject to significant improvement in 62 days	$10/visit - 20 to 36 visits per yr based on condition
	HPSE/VISTA	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE***
EMERGENCY CARE SERVICES			
Hospital ER Room	$50/visit; waived if admitted	$100/episode	$75/visit - waived if admitted
Physician Charges	Included in above $50 copay	Included in above $100 copay	Included in above copay
Ugent Care Facility	$10/visit	$15/visit	$35/visit
EXTENDED CARE SERVICES			
Skilled Nursing Facility	No Charge; up to 60 days per contract year	No Charge; up to 60 days per admission	No Charge - 60 days per calendar year
Hospice Care	No Charge	No Charge	No Charge - 360 days per covered period
Home Health Care	No Charge	No Charge	No Charge - 60 days per calendar year
MENTAL HEALTH Inpatient Facility	No Charge; up to 30 days per contract year	No Charge; up to 31 days/year	No Charge; up to 30 days per contract year
Outpatient Facility & Physician Offic	$20/visit; up to 20 visits per contract year	$20/visit; up to 20 visits/year	$10/individual - $5/Group-30 visits per cal.yr.
Day Treatment Facility	No Charge; up to 60 days per contract year	Not Covered	
Partial Hospitalization	Not Covered	No Charge; 2 days of partial hospitalization count 1 day toward mental/nervous benefit	No Charge; up to 30 days per contract year
SUBSTANCE ABUSE Inpatient Facility	No Charge; detoxification for alcohol/drug abus limited to 5 days	No Charge; detoxification only	No Charge; up to 30 days per contract year
Outpatient Facility	$20/visit; up to 20 visits (Combined with mental health outpatient visits)	$20/visit; up to 20 visits/year (Combined with mer health outpatient visits)	$10/Individual - $5/Group-30 visits per cal. yr.
	Maximum inpatient & outpatient lifetime benefit is $10,000	No Charge for diagnostic medical treatment for drugs & alcohol detoxification	
	HPSE/VISTA	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE***
OTHER SERVICES			
DME	No Charge	No Charge; up to $2,500 per member per year	No Charge; up to $2,500 per member per
Prosthetics	No Charge	No Charge	No Charge; up to $2,500 per member per
Orthotics	Subject to approval	Not Covered	Covered under DME
TMJ/Orthognatic	Subject to approval	No Charg when medically necessary	No Charge - subject to limitations
	No Charge; subject to limitations	No Charge; subject to limitations	No Charge

Ambulance	No Charge	No Charge; when medically necessary	No Charge
Medical Supplies	Subject to approval	No Charge; when part of medical treatment	No Charge; when part of medical treatment
Sterilization Services	No Charge; subject to authorization/ prior approval	No Charge; surgical sterilization including tubal ligations & vasectomies	No Charge; surgical sterilization including
Fertility Services	$10/visit	$10/visit; family planning services other than those services specifically described in the Covered Services section of the Member Handbook are excluded	Not Covered
Infertility Services	$25/visit; $2,000 lifetime maximum	$10 for endometrial biopsy, sperm count & hysterosalpingography	Not Covered

PRESCRIPTION DRUGS (for 30 day supply)

Generic	$7	$7	$7
Preferred Brand	$14	$20	$25
Non-Preferred Brand	$30	$35	$40
Mail Order	2 copays for 90 day supply	Not Available	2.5 copays for 90 day supply

	HPSE/VISTA	***CAPITAL HEALTH PLAN***	***UNITEDHEALTHCARE***
Member Services Phone Number	668-3000, EXT. 200	383-3311	
Medical Plan Web Site	www.hpse.com	www.capitalhealth.com	
PER PAY PERIOD PREMIUMS	***HPSE/VISTA Renewal Employee Cost***	***CAPITAL HEALTH PLAN Renewal Employee Cost***	***UNITEDHEALTHCARE Employee Cost***
Coverage Type			
Employee Only	$14.72	$14.72	$14.02
2 - Person	$30.47	$30.47	$29.03
Family	$39.01	$39.01	$37.16

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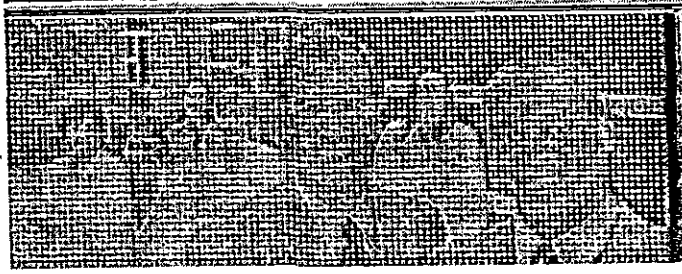
FLORIDA HMO REPORT 2003



summary results | finance
health plans | enrollment
member satisfaction | glossary
quality of care | maps
complaints | help

Site I

Dear Floridians:

With the publication of *Choosing a Quality Health Plan: Florida HMO Report 2003*, the Agency for Health Care Administration (AHCA) continues to inform consumers about the performance of health maintenance organizations (HMOs) throughout Florida. The report is designed to provide easy-to-use comparative information on each health plan doing business in Florida and currently accepting new members.

For each health plan, you will find information reflecting the many facets of managed health care. This report includes quality of care indicators, which demonstrate how well plans provide recommended check-ups and health monitoring. The results of member satisfaction surveys reveal how consumers feel about the service and access to care offered by their plans. Finally, the section summarizing complaints and requests for assistance offers insight into how well plans respond to providers and members.

A new feature of this report is the member survey of parents with children. The member survey was expanded to include questions about satisfaction with care provided to children up to twelve years of age. These results are presented for the first time in this edition.

For your convenience, this report and the previous editions are available on www.FloridaHealthStat.com along with a wide variety of other health care information. You may obtain a printed copy by contacting our Call Center toll-free at 1-888-419-3456.

AHCA's mission is to champion accessible, affordable, quality health care for all Floridians. As a part of this mission, we are pleased to offer you this guide for evaluating the performance of HMOs. I trust you will find the information contained in this publication to be a valuable resource for selecting a quality health plan.

Sincerely,

Rhonda M. Medows, M.D.
Secretary

Back to Floridahealthstat.com

INTRODUCTION

The 1999 Florida Legislature passed legislation that directs the Agency for Health Care Administration (AHCA) to publish a health maintenance organization (HMO) report card.

HMOs are required to report to AHCA data that are indicators of access and quality of care such as measures of chronic disease management, preventive health care, prenatal care and checkups for children.[1] AHCA is also required to conduct an annual survey to determine the satisfaction of HMO members.[2]

AHCA has prepared *Choosing A Quality Health Plan: Florida HMO Report 2003* from reported data and other information provided by the Florida Department of Financial Services. Information is presented for commercial, Florida Medicaid and Medicare health plans doing business in Florida. The next section describes what is included and explains how to use this report.

For more information about the data used to produce this report, contact the Agency for Health Care Administration's State Center for Health Statistics at 1-850-922-5771.

To obtain additional copies, please contact AHCA's Call Center toll-free at 1-888-419-3456.

[1] *See 641.51 (9) Florida Statutes.*

[2] *See 641.58 (4) Florida Statutes.*

HOW TO USE THIS REPORT

Which health plans do you want to consider?

1. Are you considering commercial coverage purchased by you or your employer; or government-sponsored coverage through Florida Medicaid or Medicare?

2. Use the coverage maps and county listing in the back section of this report in order to see which companies offer plans in the county where you live for the type of plan (commercial, Florida Medicaid or Medicare) you need.

3. If your employer is offering certain plans to select from, then those are the ones you should review.

4. All of the plans are listed by their HMO parent company name in this report. Check the parent company and plan name cross-reference tables in the back section of this report if you do not see a familiar plan name.

5. The summary charts will give you an overview of how each health plan ranks in selected categories. Details about plan performance and member satisfaction are included in the sections that follow.

What information is included?

This report contains a variety of information about each health plan, including:

- results of an adult member satisfaction survey,
- results of a child/parent member satisfaction survey,
- quality of care indicators,
- a summary of complaints, and
- health plan enrollment.

The financial information section provides an orientation to the detailed information available from the Florida Department of Financial Services.

What information is not included?

All licensed HMOs are included as of January 1, 2003 except health plans withdrawing from the Florida market. In some cases, no information is available because the health plan is new or small (not measurable). In some cases, the HMO did not provide information (no report).

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SUMMARY RESULTS

The three tables presented here summarize plan performance and member satisfaction for commercial, Florida Medicaid and Medicare plans. Each table displays results for five indicators reflecting member satisfaction, quality of care, and complaint experience. Descriptions of the measures and sources of information are found at the beginning of each topical section (member satisfaction, quality of care, and complaint information) in this report.

Plans are ranked on selected indicators with stars assigned as follows:

★★★★★	81 – 100th percentile
★★★★	61 – 80th percentile
★★★	41 – 60th percentile
★★	21 – 40th percentile
★	0 – 20th percentile

For all indicators, five stars designate the best rank possible. The scores used to assign stars are presented later in this report.

Member Satisfaction

One indicator is included regarding the perceptions of consumers about the health plan from the member satisfaction survey. Overall Plan Satisfaction is reported for adult members. Overall Plan Satisfaction is the percentage of members giving an overall plan rating of 10 (best health plan possible) on a scale of 0 to 10.

Quality of Care

Three indicators of quality of care are included in the summary tables. For commercial and Florida Medicaid plans, the indicators are asthma medications for long-term control and well care visits for two age groups of children and adolescents. For Medicare, the indicators are breast cancer screening, controlling high blood pressure, and kidney disease screening for people with diabetes.

Complaints

The last column provides a ranking of complaints per 10,000 plan members showing five stars for the **lowest** rate of complaints.

CLINICAL SUMMARY RESULTS

	Overall Plan Satisfaction	Annual Well-Child Visit (Ages 3-6 Years)	Annual Adolescent Well Care Visit	Asthma Medications for Long-Term Control	Low Complaint Rate
Aetna Health, Inc.	★★★	★★★	★★★	★★★★	★★★
AvMed, Inc.	★★★★★	★★★★★	★★★★★	★★★	★★★★
Capital Health Plan, Inc.	★★★★★	★★★★	★★★★	★★★★★	★★★★★
CIGNA Health Care of Florida, Inc.	★★	★★★	★★	★★★★	★★★
Florida Health Care Plan, Inc.	★★★★	★★	★★★★★	★★★★	★★★★★
Health First Health Plans, Inc.	★★★★★	★★★	★★★	★★★★★	★★★★★
Health Options, Inc.	★★	★★	★★	★★★★	★★★★
Humana Medical Plan, Inc.	★★★	★	★★	★★★	★★★★
Neighborhood Health Partnership, Inc.	★★★★	★★★★★	★★★★	★	★★★
One Health Plan of Florida, Inc.	★	★	★	★★	★★
Preferred Medical Plan, Inc.	★★★★	★★	★★★★	★★★	★★★★
The Public Health Trust of Dade County/ JMH Health Plan	★★★★★	★★★★	★★★★	★★	★★★★
Total Health Choice, Inc.	★★★	★	★★	★★	★★
United Healthcare of Florida, Inc.	★★★★	★★★★	★★★	★★★★★	★★
Vista Healthplan, Inc.	★	★★★★★	★★★★★	★★	★★
Vista Healthplan of South Florida, Inc.	★★	★★★★★	★★★★★	★★	★★

*New health plan; **Not measurable; ***No report.

MEMBER SATISFACTION

This section presents the results of an HMO member satisfaction survey conducted by the Survey Program at the University of Florida's Bureau of Economic and Business Research on behalf of AHCA. Almost 7,000 adult and 6,800 child/parent members of commercial and Florida Medicaid HMOs were polled by telephone between October 2002 and January 2003 to obtain a representative sample.[3] Adults were asked about their satisfaction with their personal health care. In a separate survey, a parent, family member or guardian was asked about their satisfaction with their child's care.

The indicators reported from the satisfaction survey are listed below.

- Overall plan satisfaction
- Ease in getting a referral to a specialist
- Ease in getting any care that the member or member's doctor believed necessary
- Getting help from customer service
- A rating of how well providers communicate with members. This rating averages the following four items:

  1. How well do they listen carefully to the member?
  2. How well do they explain things in a way the member can understand?
  3. Do they show respect for what the member has to say?
  4. Do they spend enough time with the member?

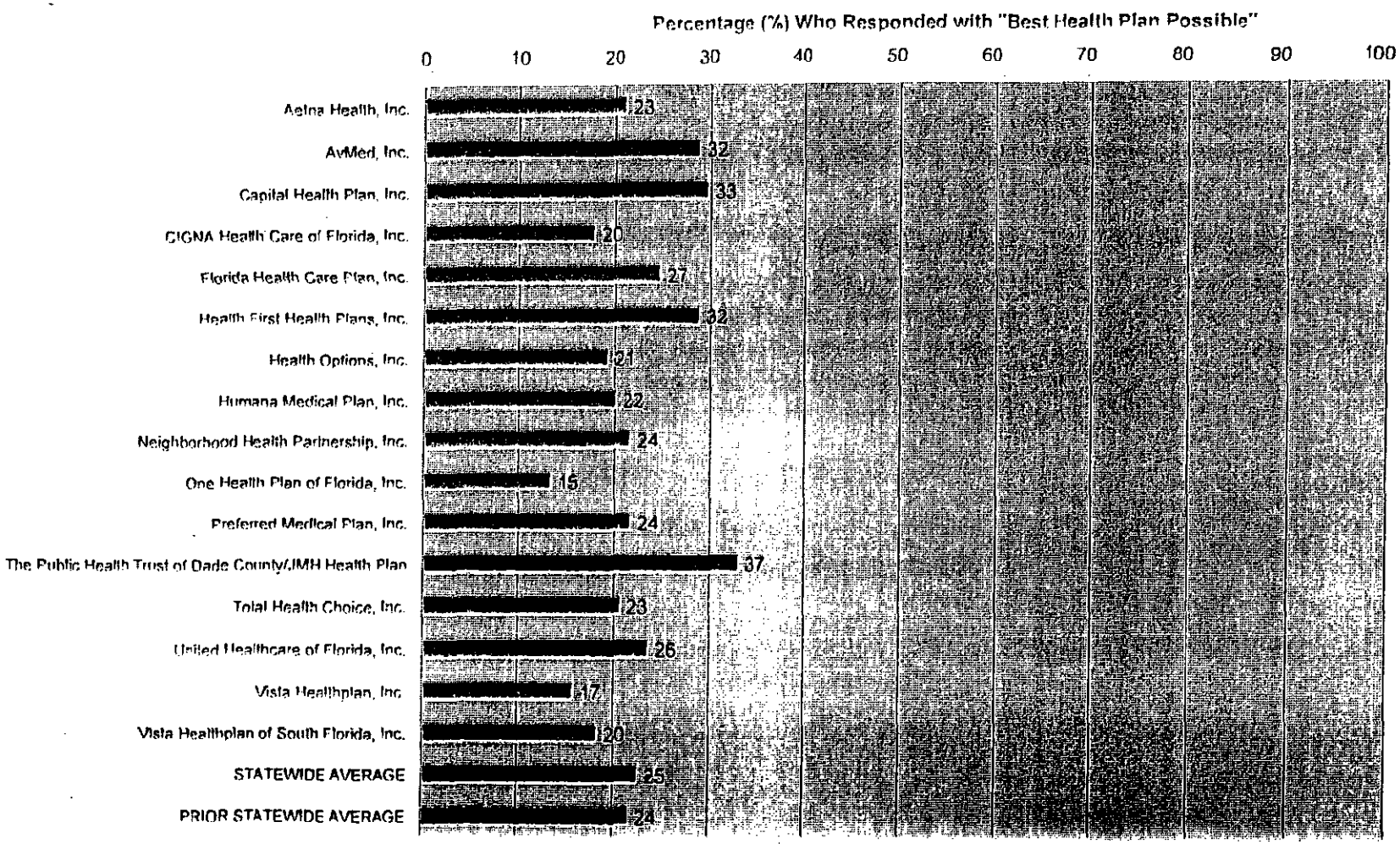
Member satisfaction information for Medicare plans includes three indicators (overall plan satisfaction, seeing a specialist, and how well providers communicate with members) from a survey performed in 2001 and reported on the national Medicare Compare web site.[4]

In addition to individual health plan data, each chart shows state averages and prior year averages. For Overall Plan Satisfaction, the charts show the percentage of members giving a rating of "10" on a scale of 0 to 10.

[3] *The survey instrument used, the Consumer Assessment of Health Plans (CAHPS version 2.0), was developed jointly by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), and the National Committee for Quality Assurance (NCQA).*

[4] *The web site by the Centers for Medicare & Medicaid Services can be accessed at www.medicare.gov.*

Adult Commercial Members - Overall Plan Satisfaction



*New health plan; **Not measurable; ***No report

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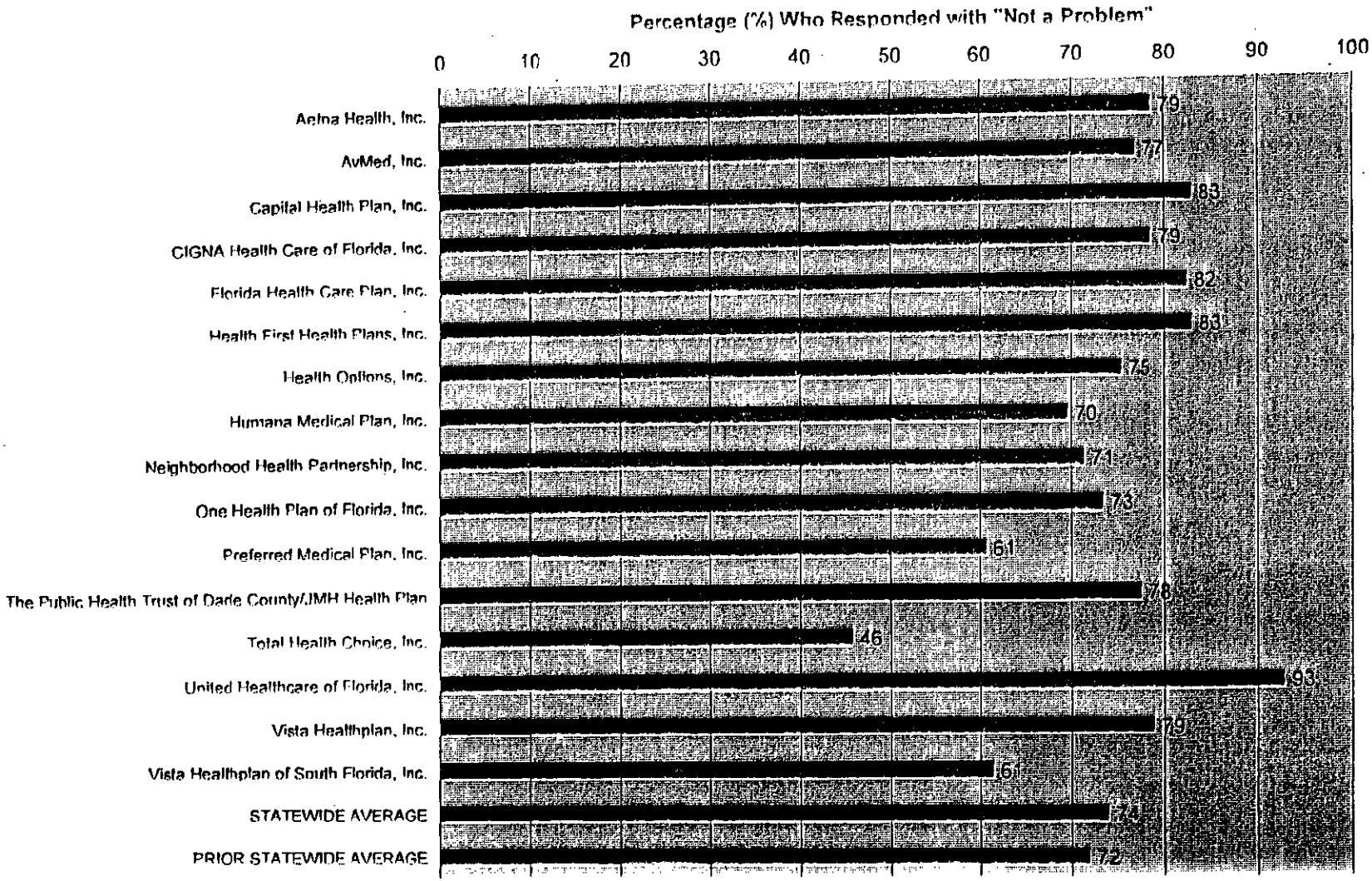
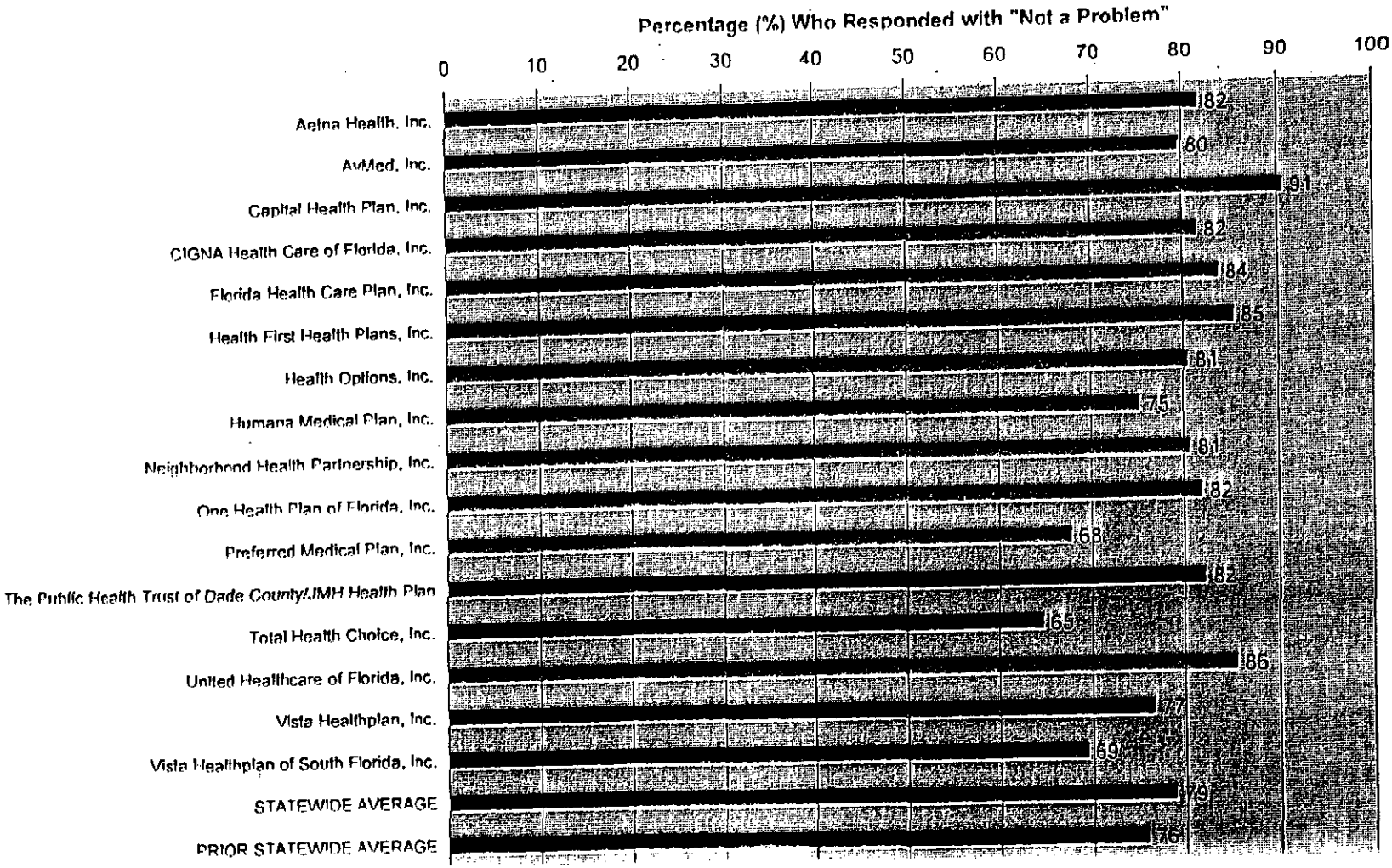
Adult Commercial Members - Ease in Getting a Referral to a Specialist



*New health plan; **Not measurable; ***No report

MEMBER SATISFACTION

Adult Commercial Members - Ease in Getting Any Care the Member or Member's Doctor Believed Necessary



*New health plan; **Not measurable; ***No report

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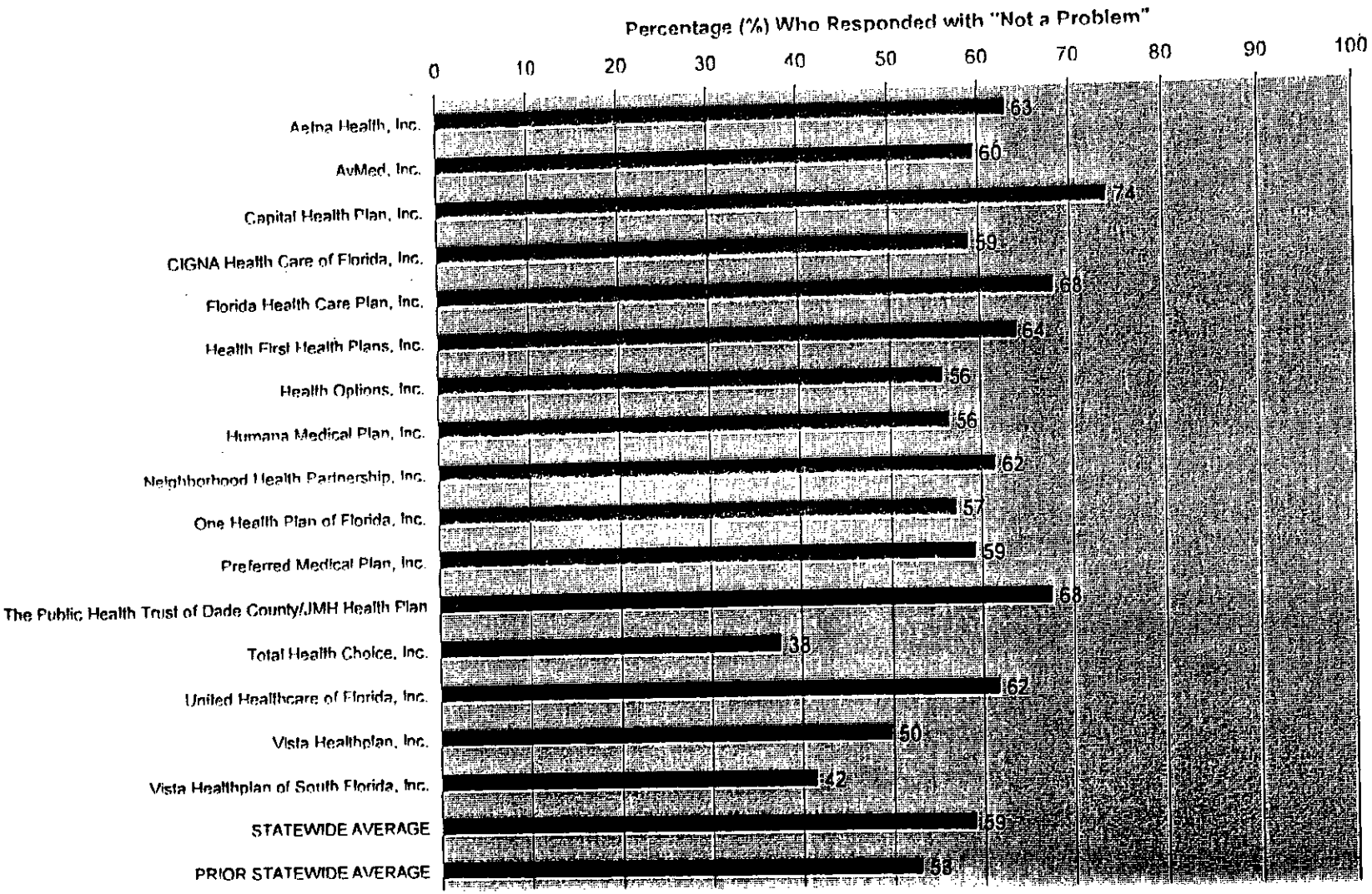
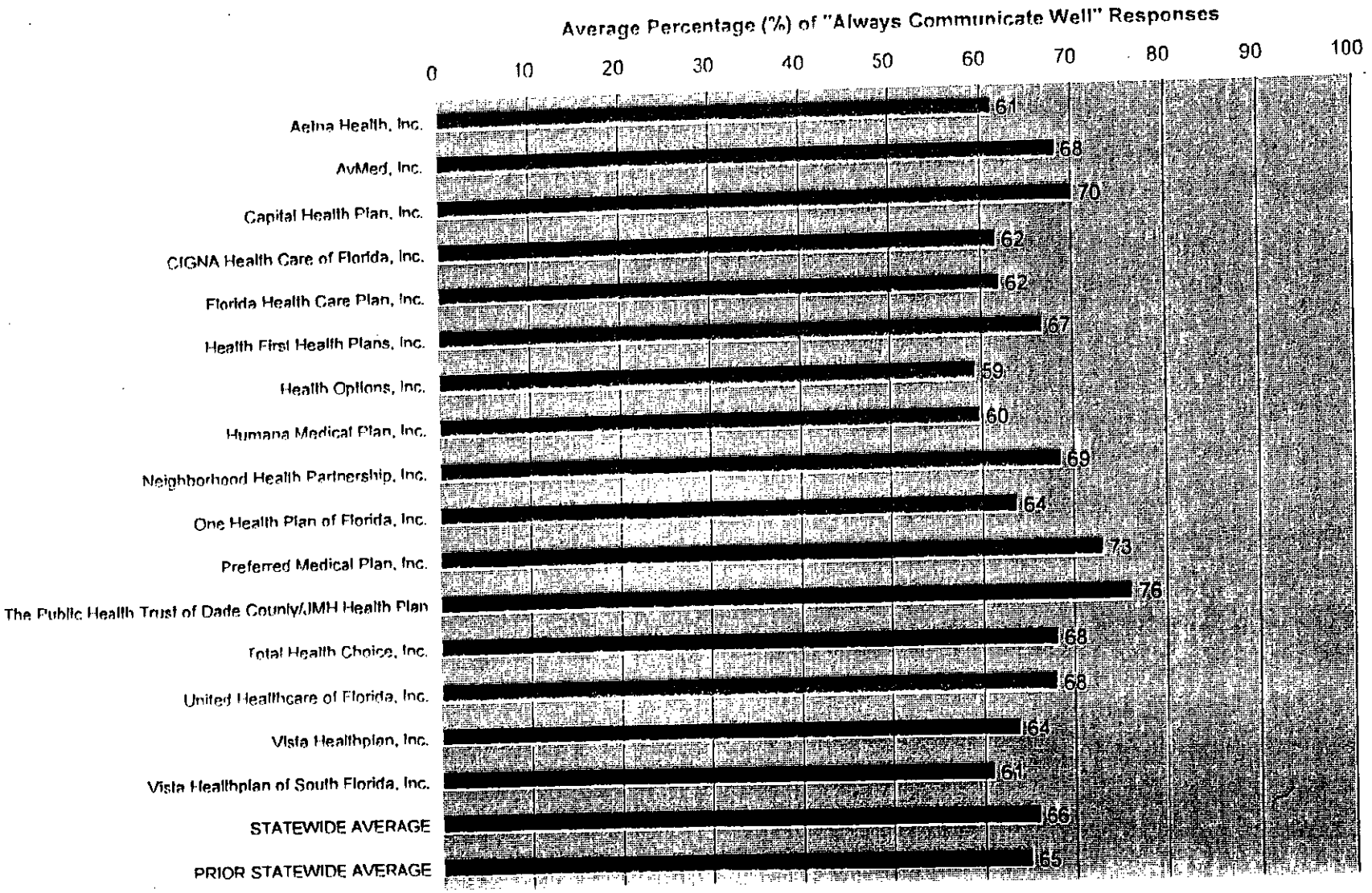
Adult Commercial Members - Getting Help from Customer Service



*New health plan; **Not measurable; ***No report

Adult Commercial Members - How Well Providers Communicate with Members



*New health plan; **Not measurable; ***No report

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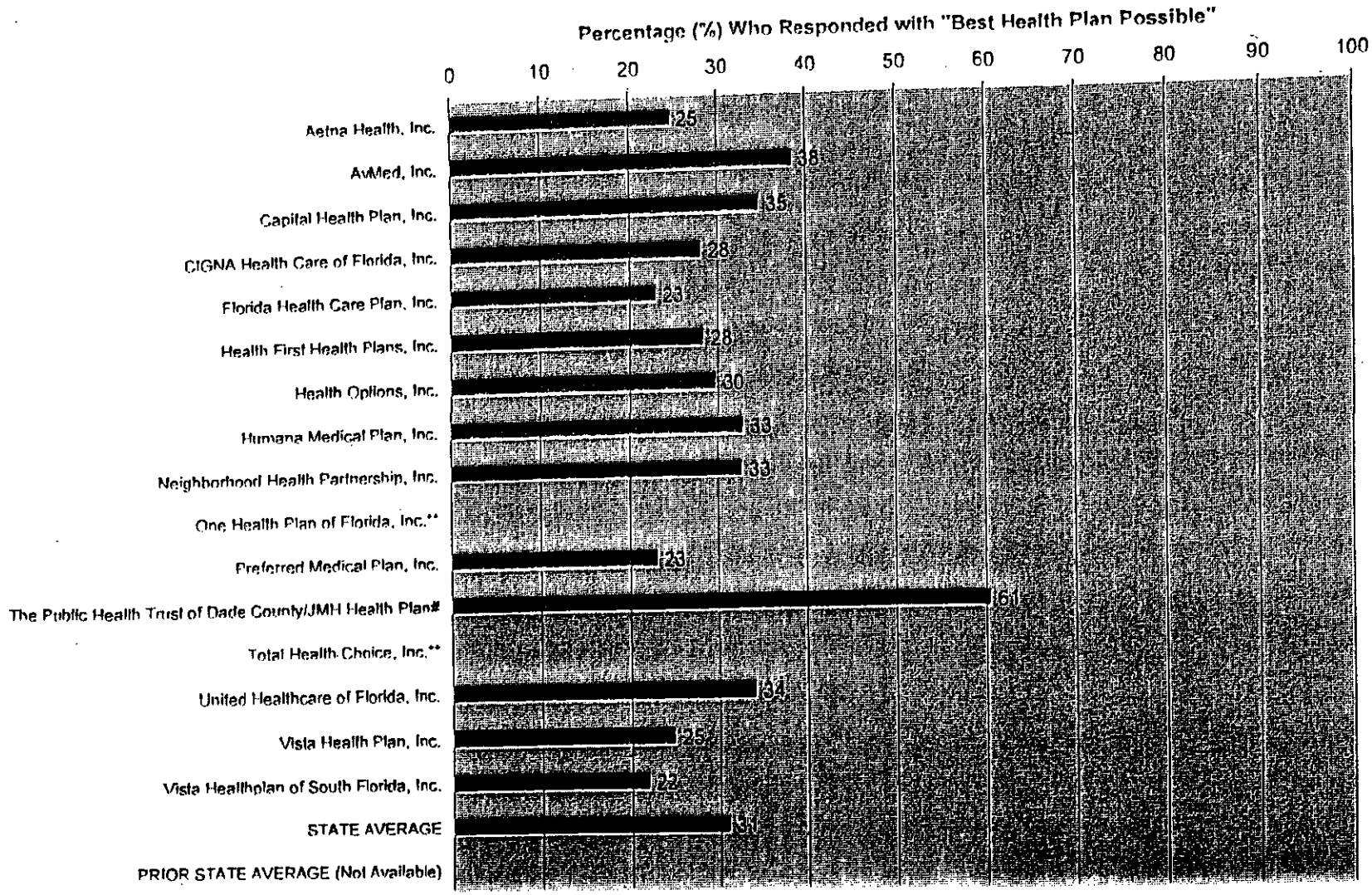
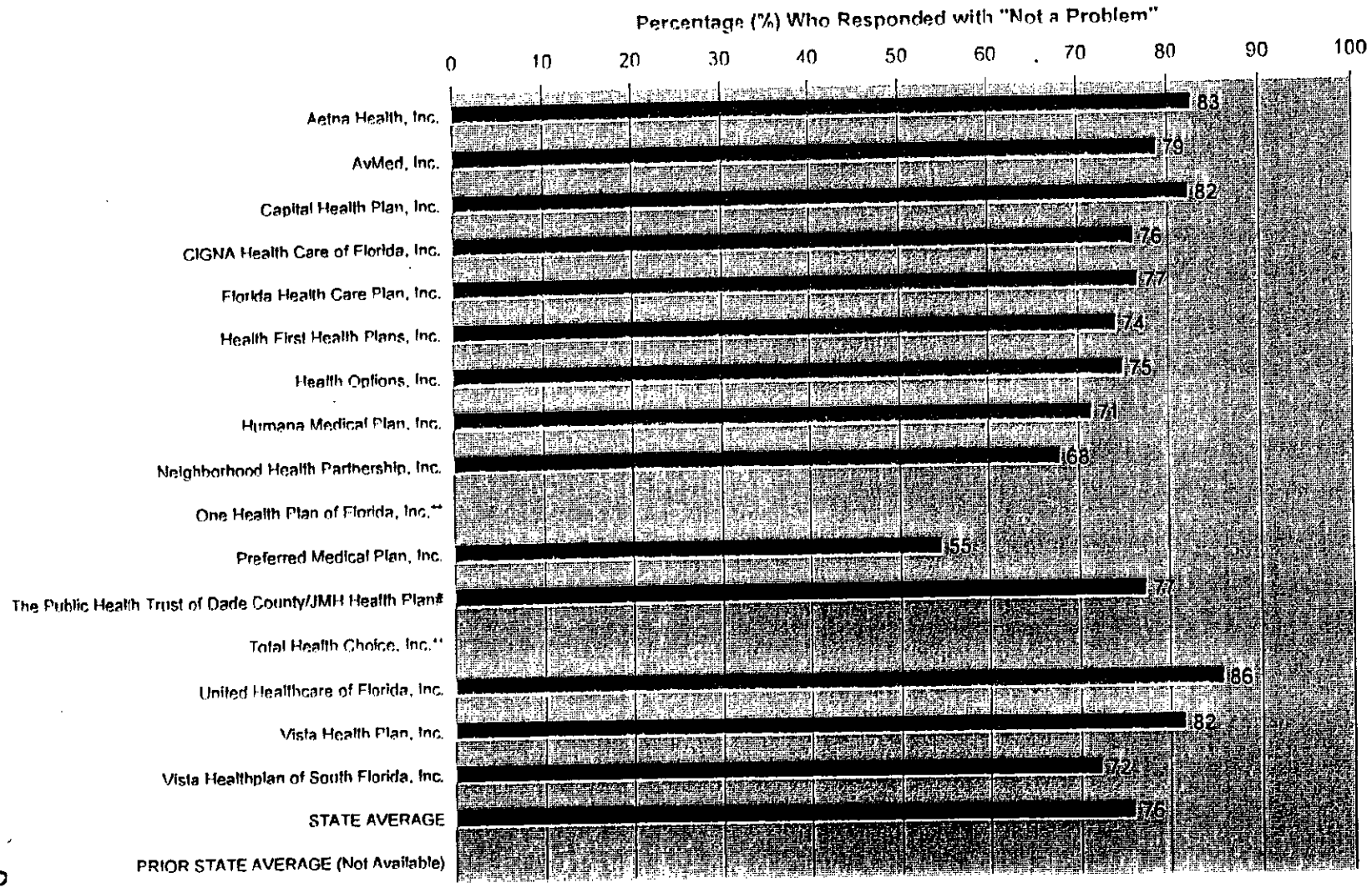
Child Commercial Members - Overall Plan Satisfaction



**New health plan; **Not measurable; ***No report; # Healthy Kids members surveyed*

Child Commercial Members - Ease in Getting a Referral to a Specialist



*New health plan; **Not measurable; ***No report; # Healthy Kids members surveyed

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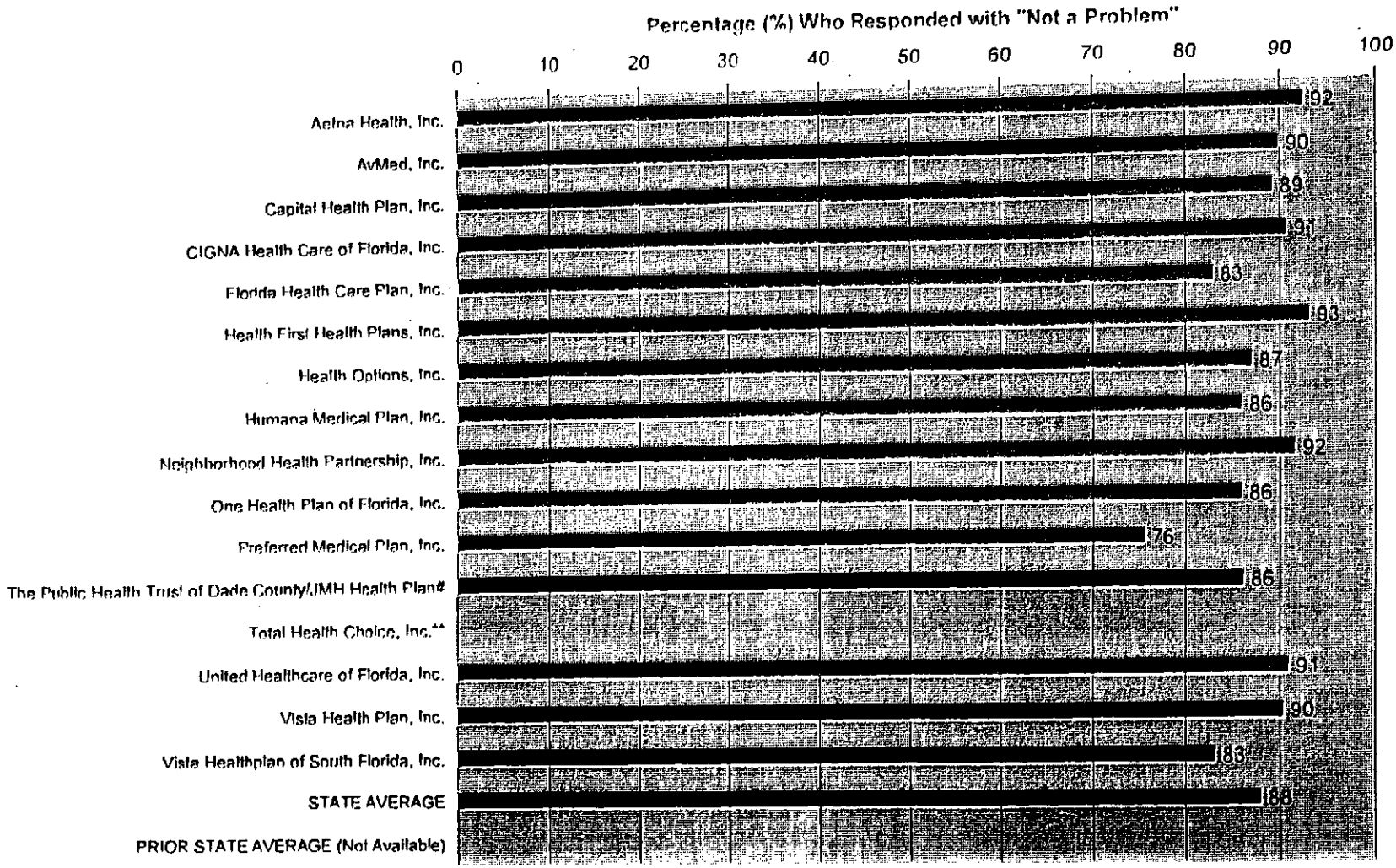
Child Commercial Members - Ease in Getting Any Care the Member or Member's Doctor Believed Necessary



*New health plan; **Not measurable; ***No report; # Healthy Kids members surveyed

Attachment # 4
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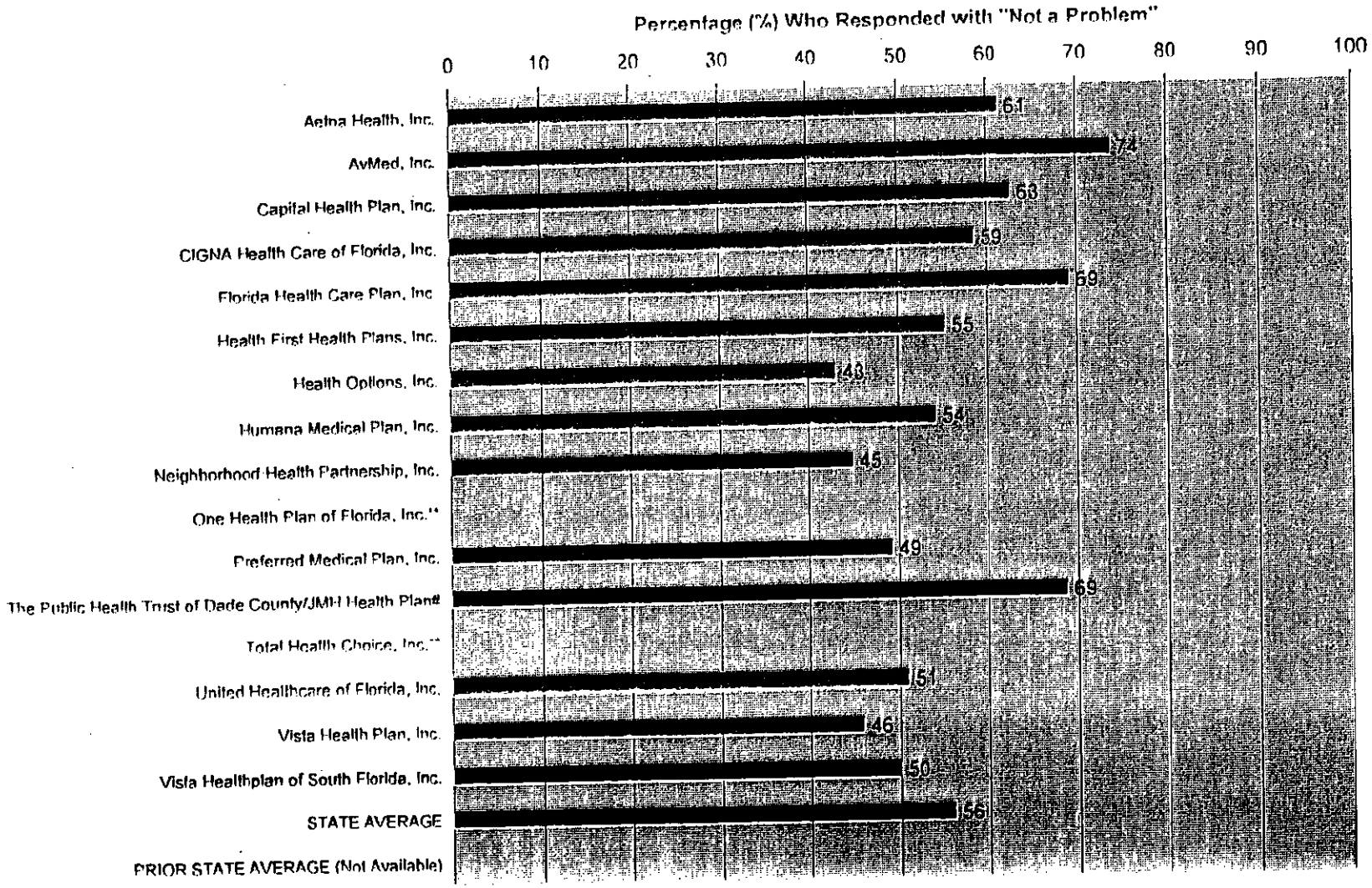
Child Commercial Members - Getting Help from Customer Service



**New health plan; **Not measurable; ***No report; # Healthy Kids members surveyed*

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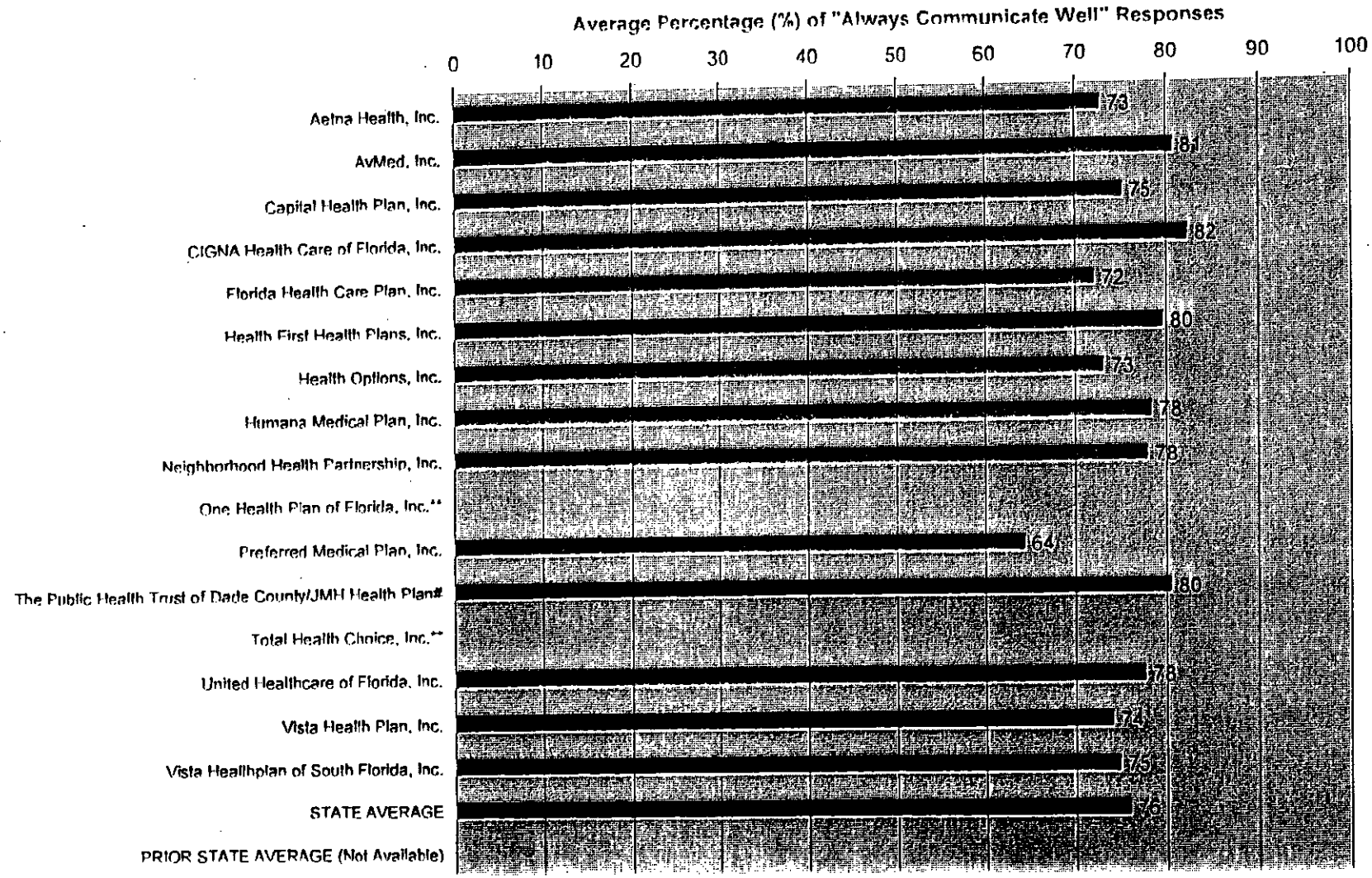
Child Commercial Members - How Well Providers Communicate with Members



**New health plan; **Not measurable; ***No report; # Healthy Kids members surveyed*

QUALITY OF CARE INDICATORS

How well do plans provide preventive health care and monitoring?

Quality of care indicators measure the size of an eligible population who have received specific health care services. For example, breast cancer screening is a quality of care indicator that reports the percentage of women between the ages of 52 and 69 who have received at least one mammogram in the past two years.

Health plans annually report a set of quality of care indicators to the Agency for Health Care Administration. The specifications for the quality of care indicators are based on HEDIS® definitions.[5] All indicators included in this report are for measurement year 2001.

Indicators reported for commercial plans include:

- Annual well child visit, ages 3-6 years
- Annual adolescent well care visit
- Asthma medications for long-term control
- Well child visits at 15 months (6 or more)

Indicators reported for Florida Medicaid plans include:

- Annual well child visit, ages 3-6 years
- Annual adolescent well care visit
- Asthma medications for long-term control

Indicators reported for Medicare plans include:

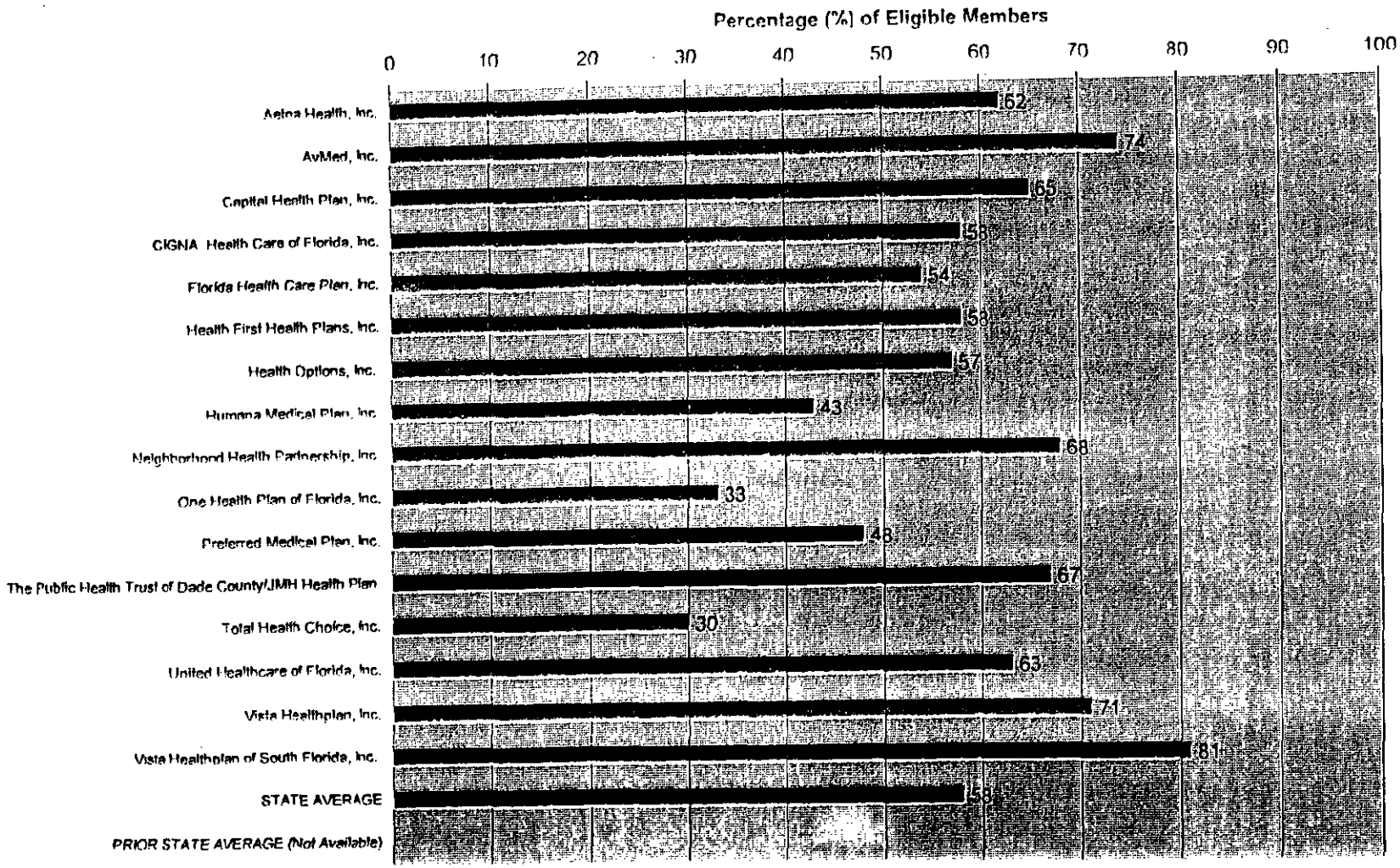
- Beta-blocker medicine prescribed after a heart attack
- Breast cancer screening
- Controlling high blood pressure
- Eye exams for people with diabetes
- Kidney disease screening for people with diabetes

Each chart shows state averages and prior year state averages are reported as available.

[5] *HEDIS® - The Health Plan Employer Data and Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a set of measures that are used to report the performance of health plans. NCQA is a private, not-for-profit accreditation organization that assesses the quality of managed care plans. More information can be obtained on the web at www.ncqa.org*

QUALITY OF CARE INDICATORS

Commercial Members - Annual Well Child Visit, Ages 3-6 Years



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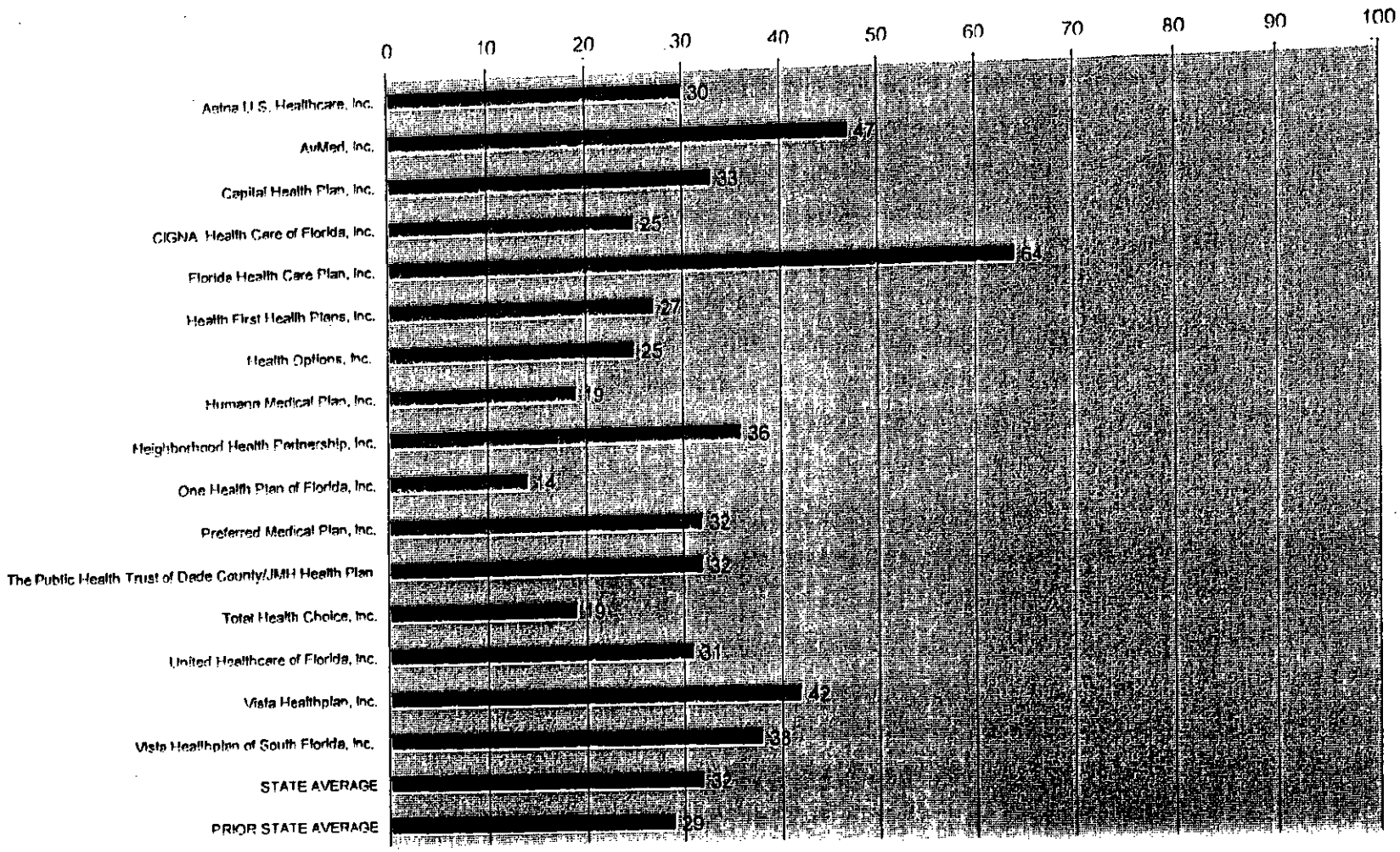
*New health plan; **Not measurable; ***No report

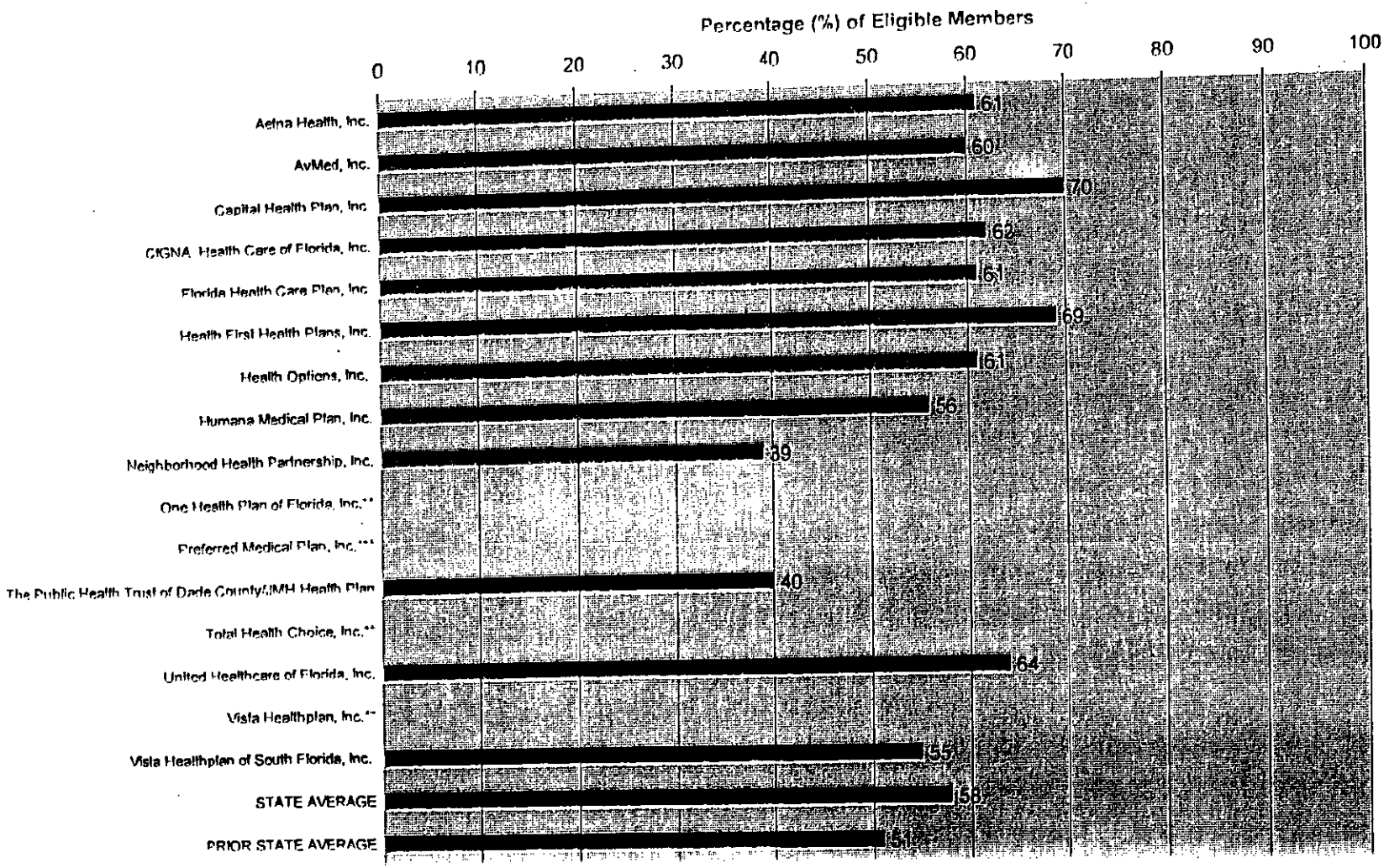
Commercial Members - Annual Adolescent Well Care Visit



*New health plan; **Not measurable; ***No report

QUALITY OF CARE INDICATORS

Commercial Members - Asthma Medications for Long-Term Control



*New health plan; **Not measurable; ***No report

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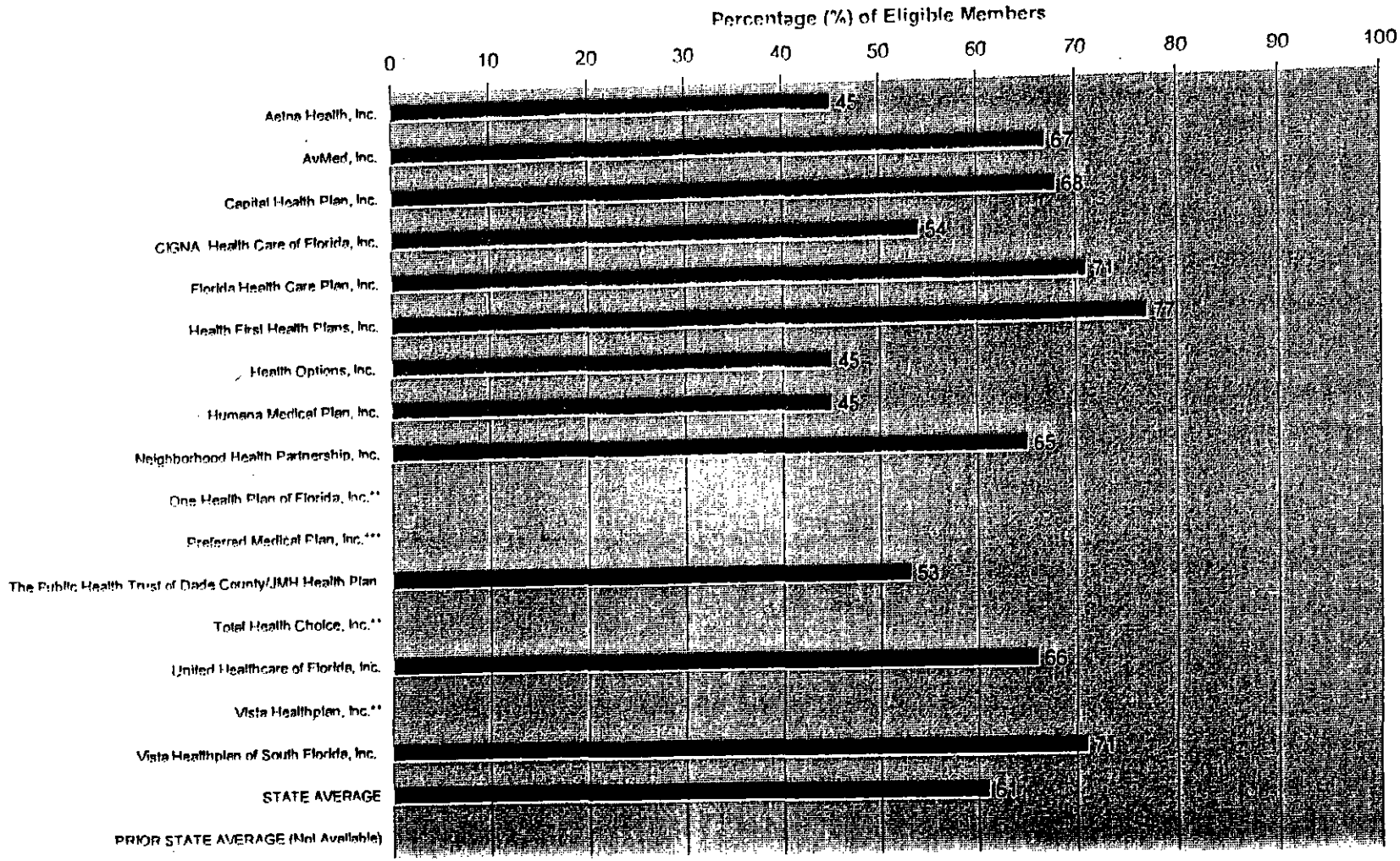
Commercial Members - Well Child Visits at 15 Months (6 or More)



*New health plan; **Not measurable; ***No report

COMPLAINT INFORMATION-COMPLAINTS RECEIVED

This section summarizes complaints received during calendar year 2002 from the following sources:

1. The Department of Financial Services (DFS)
2. The Agency for Health Care Administration (AHCA)

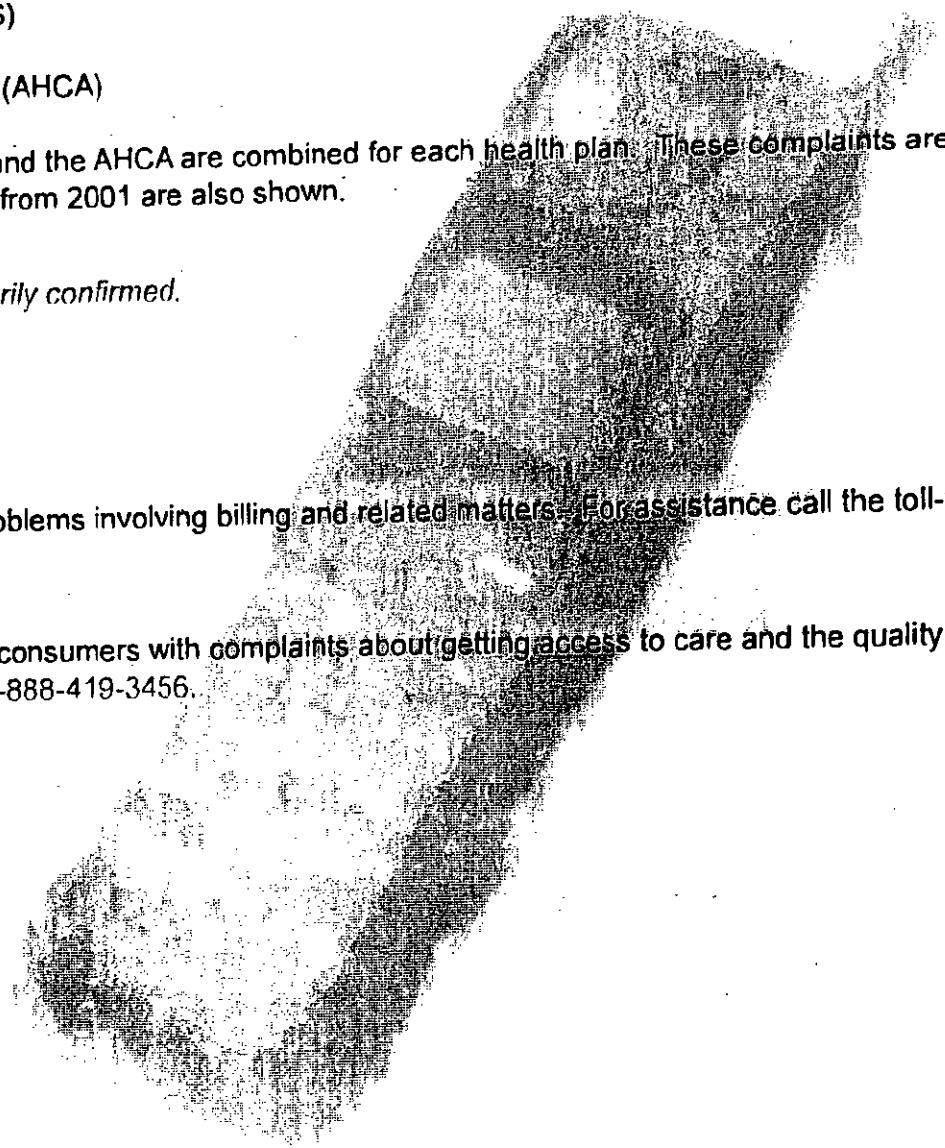
The number of complaints received by both DFS and the AHCA are combined for each health plan. These complaints are presented by plan per 10,000 members. Complaints from 2001 are also shown.

Please note that the complaints were not necessarily confirmed.

For Assistance with a Complaint

The Department of Financial Services handles problems involving billing and related matters. For assistance call the toll-free DFS Consumer Helpline at 1-800-342-2762.

The Agency for Health Care Administration helps consumers with complaints about getting access to care and the quality of care provided. Call the AHCA Call Center toll-free at 1-888-419-3456.



COMPLAINT INFORMATION

	Complaints Received Year 2002	Complaint Rate Year 2002	Complaint Rate Year 2001
Aetna Health, Inc.	827	15	10
America's Health Choice Medical Plans, Inc.	119	**	*
AMERIGROUP Florida, Inc.	198	10	12
AvMed, Inc.	319	11	14
Capital Health Plan, Inc.	18	2	1
Care Plus Health Plans, Inc.	38	11	12
CIGNA Health Care of Florida, Inc.	234	19	20
Florida Health Care Plan, Inc.	23	4	5
HealthEase of Florida, Inc.	286	19	18
Health First Health Plans, Inc.	18	4	6
Health Options, Inc.	933	12	11
Healthy Palm Beaches, Inc.	19	**	**
Humana Medical Plan, Inc.	535	12	19
Leon Medical Centers Health Plans, Inc.	*	*	*
Neighborhood Health Partnership, Inc.	290	15	14
One Health Plan of Florida, Inc.	17	**	**
Preferred Care Partners, Inc.	*	*	*
Preferred Medical Plan, Inc.	54	12	14
Quality Health Plans, Inc.	*	*	*
The Public Health Trust of Dade County/JMH Health Plan	44	10	9
Total Health Choice, Inc.	192	**	**
United Healthcare of Florida, Inc.	1398	20	15
Vista Healthplan, Inc.	772	28	30
Vista Healthplan of South Florida, Inc.	497	45	44
Well Care HMO, Inc.	529	23	32
Total Complaints/Average Rates	**7,360**	**15**	**16**

**New health plan; **Not measurable; ***No report.*

Source: AHCA and Department of Financial Services; Commercial, Florida Medicaid and Medicare complaints per 10,000 HMO members.

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COMPLAINT INFORMATION - STATEWIDE PROVIDER AND SUBSCRIBER ASSISTANCE PROGRAM

This section summarizes the outcome of cases referred to the Statewide Provider and Subscriber Assistance Program (SPSAP) panel (see Glossary). The program is designed to assist consumers of managed care entities, such as Health Maintenance Organizations, Prepaid Health Clinics, Prepaid Health Plans, and Exclusive Provider Organizations with grievances that have not been satisfactorily resolved.

Complaints are eligible for consideration by the Statewide Provider and Subscriber Assistance Program panel only after the complaint has been submitted and handled through the HMO's internal grievance process. Because of this requirement, there are fewer SPSAP complaints than complaint calls. The number of SPSAP panel cases ruled in favor of the HMO, ruled in favor of the member, and the number of settled cases are reported for year 2002.

The phone number of the Statewide Provider and Subscriber Assistance Program is 1-850-921-5458.

COMPLAINT INFORMATION

Statewide Provider and Subscriber Assistance Program

	Resolution of Cases			Cases, Year 2002	Commercial/ Florida Medicaid Enrollment
	Favors HMO	Split Decision*	Favors Member		
Aetna Health, Inc.	10	2	2	14	567,911
AMERIGROUP Florida, Inc.	1	1	2	4	190,326
AvMed, Inc.	16	7	1	24	253,378
Capital Health Plan, Inc.	2	0	0	2	102,956
CIGNA Health Care of Florida, Inc.	2	0	4	6	122,438
Florida Health Care Plan, Inc.	1	1	0	2	41,728
HealthEase of Florida, Inc.	0	0	0	0	153,365
Health First Health Plans, Inc.	3	0	0	3	32,426
Health Options, Inc.	26	3	11	40	713,268
Healthy Palm Beaches, Inc.	0	0	0	0	8,643
Humana Medical Plan, Inc.	2	5	3	10	209,952
Neighborhood Health Partnership, Inc.	1	8	1	10	156,942
One Health Plan of Florida, Inc.	0	0	0	0	7,177
Preferred Medical Plan, Inc.	0	0	0	0	44,489
The Public Health Trust of Dade County/ JMH Health Plan	0	1	0	1	43,685
Total Health Choice, Inc.	1	1	1	3	17,672
United Healthcare of Florida, Inc.	11	4	4	19	661,835
Vista Healthplan, Inc.	6	4	9	19	266,514
Vista Healthplan of South Florida, Inc.	14	5	7	26	85,050
Well Care HMO, Inc.	2	3	3	8	184,903
Total	98	45	48	191	3,864,658

*Includes 5 cases found partially in favor of member.

Source: AHCA; Commercial and Florida Medicaid cases.

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ENROLLMENT BY HEALTH PLAN

This table presents the mid-year number of members in 2002 based on enrollments reported by each plan as of June 30, 2002. Plan enrollment is separated by type of plan and totaled for all plans. These are:

- Commercial coverage, which is purchased by you or your employer;
- Florida Medicaid coverage, a government-sponsored program providing health care to qualified low-income families and individuals; and
- Medicare, also a government-sponsored program available to seniors 65 and older, or other qualified individuals.

ENROLLMENT BY HEALTH PLAN

	Commercial Plans	Florida Medicaid Plans	Medicare Plans	Total, All Plans
Aetna Health, Inc.	567,911	0	0	567,911
America's Health Choice Medical Plans, Inc.	0	0	9,725	9,725
AMERIGROUP Florida, Inc.	63,005	127,321	0	190,326
AvMed, Inc.	225,729	27,649	26,081	279,459
Capital Health Plan, Inc.	102,956	0	4,642	107,598
Care Plus Health Plans, Inc.	0	0	33,401	33,401
CIGNA Health Care of Florida, Inc.	122,438	0	0	122,438
Florida Health Care Plan, Inc.	41,728	0	16,154	57,882
HealthEase of Florida, Inc.	0	153,365	0	153,365
Health First Health Plans, Inc.	32,426	0	16,168	48,594
Health Options, Inc.	713,268	0	72,515	785,783
Healthy Palm Beaches, Inc.	3,410	5,233	0	8,643
Humana Medical Plan, Inc.	158,218	51,734	229,931	439,883
Leon Medical Centers Health Plans, Inc.	0	0	0	0
Neighborhood Health Partnership, Inc.	142,140	14,802	34,709	191,651
One Health Plan of Florida, Inc.	7,177	0	0	7,177
Preferred Care Partners, Inc.	0	0	0	0
Preferred Medical Plan, Inc.	32,300	12,189	0	44,489
Quality Health Plans, Inc.	0	0	0	0
The Public Health Trust of Dade County/JMH Health Plan	34,101	9,584	0	43,685
Total Health Choice, Inc.	17,672	0	0	17,672
United Healthcare of Florida, Inc.	625,575	36,260	52,933	714,768
Vista Healthplan, Inc.	226,765	39,749	11,947	278,461
Vista Healthplan of South Florida, Inc.	75,894	9,156	25,210	110,260
Well Care HMO, Inc.	24,968	159,935	42,640	227,543
TOTAL	**3,217,681**	**646,977**	**576,056**	**4,440,714**

Source: Department of Financial Services, June 30, 2002.

Agency for Health Care Administration (AHCA): The state agency that licenses and regulates health care facilities and health maintenance organizations in Florida. AHCA also administers the Florida Medicaid program that provides health care to Florida's low-income citizens.

Annual Adolescent Well Care Visit: A quality of care indicator that measures the adequacy of well care for adolescents ages 12 through 21 years. It estimates the percentage of adolescents who had one or more well care visits in the measurement year. Regular check-ups are the best way to detect physical, developmental, and emotional problems.

Annual Well Care Visit, Ages 3-6 Years: A quality of care indicator that measures the adequacy of well care for children ages 3 through 6 years. It estimates the percentage of children who had one or more well care visits in the measurement year. Regular check-ups are the best way to detect physical, developmental, and emotional problems.

Asthma Medications for Long-Term Control: A quality of care indicator that estimates the percentage of children and adults, ages 5 through 56 years, with persistent asthma who were prescribed medications appropriate for long-term control of asthma during the measurement year. Some medications provide short-term relief of asthma symptoms; however, these medicines cannot prevent subsequent asthma attacks.

Beta-Blocker Medicine Prescribed After a Heart Attack: A quality of care indicator that estimates the percentage of members ages 35 years and older who were hospitalized for a heart attack and received a prescription for a beta-blocker at the time of discharge from the hospital. Excluded are people who have a valid medical reason for not taking a beta-blocker medicine. People who have had a heart attack are at a higher risk for having another one. Beta-blockers can help lower the risk of another heart attack.

Breast Cancer Screening: A quality of care indicator that measures how often women are screened for breast cancer. It estimates the percentage of females, ages 52 through 69 years, who have had at least one mammogram during the measurement year or the year prior. Early detection and treatment increase the survival rate of breast cancer patients.

Complaint: Any expression of dissatisfaction by an HMO subscriber with the administration, claims payment, or provision of services.

Consumer Assessment of Health Plans Survey (CAHPS): A survey that assesses the member satisfaction with the performance of the health plan. CAHPS was developed by the U.S. Department of Health and Human Services.

Controlling High Blood Pressure: A quality of care indicator that estimates the percentage of adults, ages 46 through 85 years, with diagnosed high blood pressure who had their blood pressure adequately controlled (systolic pressure under 140mm and diastolic pressure under 90mm) during the measurement year. Persons with uncontrolled high blood pressure have a greater risk of stroke and heart disease.

Department of Financial Services (DFS): The state agency that oversees rates and regulations in the insurance, banking and finance industries of Florida and helps consumers with problems related to financial services, including banking, securities and insurance.

GLOSSARY (CONTINUED)

Eye Exams for People with Diabetes: A quality of care indicator that estimates the percentage of diabetic plan members, ages 18 through 75 years, who received an eye exam in the measurement year. Diabetes is the leading cause of adult blindness in the U.S., which makes it important that diabetics have their eyes examined regularly so that appropriate treatment can be initiated at the first sign of a problem.

Florida Medicaid: A state-administered medical program that serves low-income families, those age 65 and older, people who are blind, and people who are disabled.

Health Maintenance Organization (HMO): An organized system for providing comprehensive prepaid health care. HMOs provide care in a defined geographic area; provide or ensure delivery of an agreed-upon set of basic and supplemental health maintenance and treatment services; provide care to a voluntarily enrolled group of persons; require their enrollees to use the services of designated providers; and receive a predetermined, fixed, periodic prepayment made by or on behalf of the member. HMOs are licensed and reviewed by government agencies such as Agency for Health Care Administration (AHCA) to ensure compliance with state and/or federal regulations.

Health Plan Employer Data & Information Set (HEDIS): A set of measures that are used to report the performance of health plans. The measures evaluate the organizational structure and systems of the HMO and the performance in delivering care. HEDIS was created by the National Committee for Quality Assurance (NCQA).

Kidney Disease Screening for People with Diabetes: A quality of care indicator that estimates the percentage of diabetic plan members, ages 18 through 75 years, who were screened or treated for kidney disease (diabetic nephropathy) during the measurement year. Diabetes affects multiple organs in the body including the kidneys. Kidney failure can be prevented if detected and addressed in the early stages.

Medicare: A federal health insurance program that serves people age 65 and older or disabled persons, regardless of income.

National Committee for Quality Assurance (NCQA): A private, not-for-profit accreditation organization that reports on the quality of managed care plans. Other organizations that accredit HMOs in Florida are the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC).

Statewide Provider and Subscriber Assistance Program (SPSAP): A program to provide assistance to plan members and providers whose grievances are not resolved to their satisfaction by the HMO. The consumer must first complete the entire grievance process of the health plan before filing a grievance with the program, unless the grievance is of an urgent nature. Under this program, a panel reviews the grievance and makes a recommendation to AHCA or the Florida Department of Financial Services.

Well Child Visits at 15 Months (Six or More Visits): A quality of care indicator that measures the adequacy of well care for infants. It estimates the percentage of children who had 6 or more well child visits by the 15th month of age. Regular check-ups are the best way to detect physical, developmental, and emotional problems.

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COMMERCIAL HEALTH PLANS BY COUNTY

Alachua
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Baker
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.

Bay
None

Bradford
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Brevard
Aetna Health, Inc.
CIGNA Health Care of Florida, Inc.
Health First Health Plans, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.

Broward
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Neighborhood Health Partnership, Inc.
One Health Plan of Florida, Inc.
Preferred Medical Plan, Inc.
The Public Health Trust of Dade County/JMH Health Plan
Total Health Choice, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Calhoun
Vista Healthplan, Inc.

Charlotte
Aetna Health, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.

Citrus
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.

Clay
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Collier
United Healthcare of Florida, Inc.

Columbia
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

DeSoto
Health Options, Inc.
United Healthcare of Florida, Inc.

Dixie
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan, Inc.

Duval
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan of South Florida, Inc.

Escambia
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Flagler
Aetna Health, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Franklin
Vista Healthplan, Inc.

Gadsden
Capital Health Plan, Inc.
Vista Healthplan, Inc.

Gilchrist
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan, Inc.

Glades
Humana Medical Plan, Inc.
Vista Healthplan, Inc.

Gulf
None

Hamilton
AvMed, Inc.
Vista Healthplan, Inc.

Hardee
Humana Medical Plan, Inc.

Hendry
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan, Inc.

Hernando
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Highlands
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Hillsborough
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

COMMERCIAL HEALTH PLANS BY COUNTY

Holmes
None

Indian River
Aetna Health, Inc.
Humana Medical Plan, Inc.

Jackson
None

Jefferson
Capital Health Plan, Inc.
Vista Healthplan, Inc.

Lafayette
Vista Healthplan, Inc.

Lake
Aetna Health, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Lee
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.

Leon
AvMed, Inc.
Capital Health Plan, Inc.
Vista Healthplan, Inc.

Levy
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan, Inc.

Liberty
Vista Healthplan, Inc.

Madison
Vista Healthplan, Inc.

Manatee
Aetna Health, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.

Marion
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Martin
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan of South Florida, Inc.

Miami-Dade
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Neighborhood Health Partnership, Inc.
One Health Plan of Florida, Inc.
Preferred Medical Plan, Inc.
The Public Health Trust of Dade County/JMH Health Plan
Total Health Choice, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Monroe
None

Nassau
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Okaloosa
Health Options, Inc.
United Healthcare of Florida, Inc.

Okeechobee
Aetna Health, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.

Orange
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Osceola
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Palm Beach
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Neighborhood Health Partnership, Inc.
One Health Plan of Florida, Inc.
Total Health Choice, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Pasco
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Pinellas
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Polk
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.

Putnam
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

St. Johns
Aetna Health, Inc.
AvMed, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

St. Lucie
Aetna Health, Inc.
Health Options, Inc.
Vista Healthplan of South Florida, Inc.

Santa Rosa
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Sarasota
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Health Options, Inc.

Seminole
Aetna Health, Inc.
AvMed, Inc.
CIGNA Health Care of Florida, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan of Florida, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Sumter
Health Options, Inc.

Suwannee
AvMed, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Taylor
None

Union
AvMed, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Volusia
Aetna Health, Inc.
CIGNA Health Care of Florida, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.

Wakulla
Capital Health Plan, Inc.
Vista Healthplan, Inc.

Walton
Health Options, Inc.

Washington
None

Capital Health
PLAN

September 17, 2004

Lillian Bennett
Director, Human Resources/Risk Management
Leon County Board of County Commissioners
Leon County Courthouse, Suite 201
Tallahassee, FL 32301

Dear Lillian,

I was surprised by the motion of the of the Leon County Board of County Commissioners instructing you to report on the feasibility of adding United Health Care as a third health care option. What was equally as puzzling was that the rationale was to save the County money.

Capital Health Plan has historically offered cost saving plan options to Leon County. Specifically, for the January 2004 renewal, Capital Health Plan offered a Plan option that is equivalent to the one offered by all other local State and county governments that would have resulted in a $1,000,000 premium savings this year. The same option was offered for 2005 and would have resulted in $500,000 savings. Over the years, Capital Health Plan has even discussed the possibility of partnering through our affiliation with Blue Cross Blue Shield of Florida to offer a dual PPO and HMO option.

Capital Health Plan has a twenty-one year history of providing quality health care to the employees and families of Leon County as well as the entire four county community that we serve. We are locally based and employ approximately 500 physicians, nurses, and administrative staff who support our efforts to achieve both local and national recognition for member satisfaction and quality of care. Per your request, we reviewed the directory of physicians you provided to us and it appears that over 50% of the CHP's Leon County members have primary care physicians that are not available through United.

We take our long term relationship with Leon County and our responsibility to manage medical costs very seriously. However, due to the underwriting instability associated with adding a third plan, Capital Health Plan cannot agree to be offered as one of three separate carriers for county employees. This arrangement creates too great an opportunity for adverse selection and instability in the risk pool. Carriers with weaker delivery systems or delivery systems that do not include specific specialists, tend to avoid attracting enrollees with certain high cost diseases – thereby benefiting from being

2140 Centerville Place • Tallahassee, Florida 32308
P.O. Box 15349 • Tallahassee, Florida 32317-5349
Telephone (850) 383-3300 • Web Page: http://www.capitalhealth.com
Independent Licensee of the Blue Cross and Blue Shield Association

offered alongside a strong plan. Please be assured that Capital Health Plan is supportive of competition for value but cannot support creating competition that works to compete only for the healthy portion of the risk pool. Our focus has been and continues to be on keeping high quality benefits as affordable as possible for Leon County and its employees and we would welcome an opportunity to discuss options for cost savings and for adding choice for your employees.

Please feel free to call me if you have any questions or need additional information.

Sincerely,

Terry Steaple
Sales Director

Attachment # 4
Page 67 of 68

From: "Hutchinson, Mary" <Mary.Hutchinson@vistahealthplan.com>
To: <PoirierE@mail.co.leon.fl.us>
Date: 9/17/2004 11:25:03 AM
Subject: United As Third Option for Leon County for 2005

Ernie, it is Vista's official position that we do not object to United Health Care as a third option for Leon County employees for the 2005 Plan Year. Additionally, the rates we proposed for Leon County for the 2005 Plan Year will not change if United is offered as a third option.

Mary Hutchinson
State and Federal Products Manager

CC: "Glennon, Tom" <Tom.Glennon@vistahealthplan.com>, "Townsend, Nicole" <Nicole.Townsend@vistahealthplan.com>

BOARD OF COUNTY COMMISSIONERS

301 South Monroe Street
Tallahassee, Florida 32301
(850) 488-4710

January 5, 2005

Superintendent Bill Montford
Leon County Schools
2757 West Pensacola Street
Tallahassee, Florida 32304

Re: Employee Health Insurance Partnership

Dear Superintendent Montford:

For many years now, Leon County has experienced significant increases in employee health care costs and it appears that this trend will continue into the future. To address this issue, the Leon County Board of Commissioners will be reviewing alternatives to reduce the cost of employee health care coverage.

As a part of this effort, the Board has requested that I seek the Leon County School Board's interest in participating with Leon County in establishing an Employee Health Care Consortium to consolidate health benefit plans. The ultimate goal of the consortium would be to control the rising costs of health care for employees without compromising the benefit levels already afforded to them. Additionally, I am contacting Mayor John Marks, City of Tallahassee to determine if the City would consider partnering with us as well in this effort.

I believe that pooling the resources of the City, County and the School Board, would give us the leverage needed to develop a health benefit plan that would meet our collective needs, provide the highest quality of benefits and secure a palatable cost structure. Please consider this invitation to become a partner with Leon County in this effort and notify me of your interest by January 20, 2005.

Should you have any questions, please contact me or Lillian Bennett, Director of Human Resources at 487-2220. I appreciate your time and consideration and I look forward to hearing from you soon.

Sincerely,

Cliff Thaell, Chairman
Leon County Board of Commissioners

cc: Leon County Commissioners
City of Tallahassee Commissioners
Parwez Alam, County Administrator
Anita Favors, City Manager

BOARD OF COUNTY COMMISSIONERS
301 South Monroe Street
Tallahassee, Florida 32301
(850) 488-4710

January 5, 2005

The Honorable Mayor John Marks
City of Tallahassee
300 South Adams Street
Tallahassee, Florida 32301

Re: Employee Health Insurance Partnership

Dear Mayor Marks:

For many years now, Leon County has experienced significant increases in employee health care costs and it appears that this trend will continue into the future. To address this issue, the Leon County Board of Commissioners will be reviewing alternatives to reduce the cost of employee health care coverage.

As a part of this effort, the Board has requested that I seek the City of Tallahassee's interest in participating with Leon County in establishing an Employee Health Care Consortium to consolidate health benefit plans. The ultimate goal of the consortium would be to control the rising costs of health care for employees without compromising the benefits levels already afforded to them. Additionally, I am contacting Bill Montford, Superintendent of Schools to determine if the Leon County School Board would consider partnering with us as well in this effort.

I believe that pooling the resources of the City, County and the School Board, would give us the leverage needed to develop a health benefit plan that would meet our collective needs, provide the highest quality of benefits and secure a palatable cost structure. Please consider this invitation to become a partner with Leon County in this effort and notify me of your interest by January 20, 2005.

Should you have any questions, please contact me or Lillian Bennett, Director of Human Resources at 487-2220. I appreciate your time and consideration and I look forward to hearing from you soon.

Sincerely,

Cliff Thaell, Chairman
Leon County Board of Commissioners

cc: Leon County Board of Commissioners
City of Tallahassee Commissioners
Parwez Alam, County Administrator
Anita Favors, City Manager

Attachment # 6
Page 1 of 1

January 19, 2005

Mr. Cliff Thaell, Chairman
Leon County Board of Commissioners
301 South Monroe Street
Tallahassee, FL 32301

RE: Employee Health Insurance

Dear Chairman Thaell:

In response to your letter of January 5, 2005, we are interested in considering the establishment of the consortium you described as an approach to moderating the recent increase in healthcare costs. We would welcome the inclusion of the City of Tallahassee in such discussions.

With regard to a coordinated cooperative approach to this issue, we are currently participating in a healthcare feasibility study coordinated by the Panhandle Area Educational Consortium (PAEC), comprised of the Florida Panhandle school districts. This study will result in recommendations by the Marsh and Mercer benefit consulting firms later this spring as to the feasibility of cost savings resulting from a coordinated approach to one or more components of our healthcare programs. This effort is in the exploratory phase and does not limit our ability to consider other cooperative approaches that may be available to us.

If you have questions regarding the PAEC feasibility study or any other aspect of our current healthcare program, you may address them to me or Jim Parry, Chief of Labor Relations and Legal Advisor, at 487-7103 or at parryj@mail.leon.k12.fl.us.

Thank you for inviting us to undertake this initiative. We look forward to discussing this matter further with you and your staff in the near future.

Sincerely

William J. Montford
Superintendent

cc: Jim Croteau, Assistant Superintendent Business Services
Jim Parry, Chief of Labor Relations and Legal Advisor
Dave Giordano, Director of Personnel Services
Linda Dekle, Employee Related Services

Capital Health
PLAN

History of Capital Health Plan's Development

Originally established in 1982, CHP was the area's first health maintenance organization. It was created by local citizens concerned with the rising cost of health care and the need for an alternative system of health care delivery. CHP is governed by a local Board of Directors consisting of many of the founding community leaders who represent a cross-section of business, government, health care and community backgrounds. It is the responsibility of the Board to establish the major policies under which CHP operates.

While the Plan initially served state government employees and their dependents, as the 1980s progressed, other major employer groups were added and membership grew steadily. The partnership between CHP and Leon County began November 1, 1983. At that time Leon County had 665 eligible employees, 271 of which enrolled in CHP's initial offering, representing 41% of the total eligible employees.

Capital Health Plan ("CHP") is a mixed model HMO combining the advantages of two modern health center complexes where over 500 physicians, nurses, allied health care professionals and administrative staff directly employed by CHP provide coordinated care for Plan Members. The health centers have the convenience of on-site lab, x-ray, and vision care. In addition, CHP offers members the choice of an extensive network of affiliated primary and specialty care physicians located throughout the service area.

CHP health centers are located at 2140 Centerville Place and 1491 Governors Square Boulevard and an administrative service center is located at 1545 Raymond Diehl Road in Tallahassee. These central locations provide Members with easy access to physicians, support personnel and necessary information about their health benefits coverage.

The Plan has historically reinvested revenues into benefit package and health care network expansion. A prescription drug benefit was added in 1985 when CHP opened its two pharmacies and was expanded in 1986. The vision benefit was added in 1986 with the opening of the CHP Eye Care Center at the Centerville health care complex. Hundreds of area physicians, the area hospitals and numerous allied health professionals are now part of the CHP provider network. A new primary care medical facility was opened in early 1998 on Governors Square Boulevard, providing members with an additional accessible location. An Urgent Care facility is now available to all CHP members with the most expanded hours of operation available within our community. Members with a need for care not available locally are offered tertiary referral to the highly respected University of Florida Shands, Mayo Jacksonville and Moffitt health centers.

In 2004, Capital Health Plan expanded member access to out of area urgent and emergency care at any affiliated Blue Cross and Blue Shield provider in the country through the BlueCard® network. With 80% of all hospitals and 90% of all physicians, this is the largest health care network in the United States. In addition, CHP announced a national affiliation with Walgreens pharmacy allowing members to access their pharmacy benefit out of the area at more than 4,400 stores in 44 states.

CHP has continued to meet the challenges of providing high quality and cost effective care through a well organized local delivery system. Our relationships with area employer groups have been focused on meeting the long term needs of their employees through prevention, coordination of care and the use of evidence based medicine. Disease management and health promotion are strong components of the Plan.

CHP continues to seek ways to better serve its members and the community by emphasizing our commitment to quality, services and cost-effective care. Many area businesses both large and small currently provide their employees with access to membership. Today CHP serves more than 112, 000 Members and over 2,800 area employers.

Capital Health PLAN

Engaging Healthcare Consumers

CHP continues to maintain a national benchmark status in member satisfaction scores among the top in the nation reporting to NCQA. In 2004, NCQA ranked CHP among the top 10 accredited health plans in the nation on HEDIS® Member Satisfaction measures and among the top 5 in the Southeast on Effectiveness of Care. CHP is the only plan in the southeast United States to achieve this distinction.

Highly managed plans are also those that achieve the greatest overall cost management, an achievement that can conflict with member satisfaction. Capital Health Plan is unique locally and nationally in achieving the promises of managed care while maintaining a high level of member and physician satisfaction.

Capital Health Plan continues to pursue important goals that will:

(1) Control the rate of increase in healthcare costs going forward,
(2) Ultimately improve the overall health of the population, and
(3) Engage employees in becoming more knowledgeable about their healthcare choices.

Capital Health Plan is focused on providing its members with the appropriate tools to help them become better health care consumers. A long standing commitment to primary and secondary prevention is described in the following examples of current and ongoing efforts:

1. CHP's disease management programs in diabetes, asthma, coronary artery disease, end-stage renal disease and depression are "opt-out" programs. Participants with these diagnoses are automatically enrolled in these programs and excluded only on their request. Ongoing services provided for members with these chronic conditions include:
    - Individual assessment and case management services for patients with end-stage renal disease.
    - Individual assessment and follow-up services for patients with congestive heart failure.
    - Annual retinal eye exams and foot exams provided for diabetic members with no co-pay.
    - Pre-authorized lab requests sent to members with diabetes and coronary artery disease annually.
    - Member-specific laboratory data for diabetic and coronary artery disease patients provided to primary care physicians (PCPs) on a semi-annual basis.

- Depression screening and referral for members with diabetes, asthma, coronary artery disease, and members over the age of sixty-five.
- Peak flow meters are provided for asthma members at no cost.
- Members with asthma, diabetes and coronary artery disease, and members over the age of 65 are encouraged to receive flu and pneumococcal immunizations.
- Health assessment survey for members with diabetes, asthma and coronary artery disease conducted annually since 1998; will be conducted once every two years beginning in 2004.
- Reminders to members and PCPs when preventive health services are due.
- Member and physician education.

2. Capital Health Plan has implemented a number of unique interventions designed to continually improve clinical performance measures. These include:

- A new 'chronic care' physician practice was opened in our Governor Square Boulevard Health Center in 2003 with the hiring of Dr. John Agens, a Mayo-trained physician who is board certified in internal medicine and geriatrics. His practice is designed to care for patients with multiple chronic conditions utilizing a new chronic care treatment model that is focused on meeting the specific needs and expectations of chronically ill patients. As studies have shown, in most populations approximately 1% of the population will drive 30% of the cost and 20% of the population will drive 80% of the cost. CHP has identified the 1% of our enrolled population that drives 30% of the cost. Many of these enrollees have multiple co-morbidities and complicated medical problems. CHP's sickest patients are identified through risk analysis software and invited to participate in the Center for Chronic Care. Early results are showing promising improvements in quality and cost.
- We know from analysis of our system's data, that the components of the CHP delivery system that are most highly organized (the 30 physicians who practice within our staff model) consistently produce better outcomes related to effectiveness and cost of care. Our staff physicians care for Capital Health Plan members only, giving them the opportunity to focus on delivery of best evidence medical care within an organized support system.
- A colon screening program in our Centerville Place Health Center has been operational since September, 2002. The program has continued to expand. In the latter part of last year, phase-in of a program to allow for patient self-referral was begun. CHP provides performance data to PCPs about their colon screening rates, and sends lists to PCPs of members due for screening. Since initiation of the program members receiving fecal occult blood tests increased by 7% and those receiving endoscopy increased by 9%. Further focused interventions are planned for 2004.
- CHP's Mammography Center located in our Governors Square Blvd Center continues to offer expanded access to this important preventive service. In

2004 we began providing diagnostic mammography and ultrasound services. To date, over 15,000 women have been screened at CHP's Mammography Center.

- CHP operates an Urgent Care service that provides more extensive hours of operation than any program in the Tallahassee area. The CHP Urgent Care Center is staffed from 12 noon through 11 p.m. weekdays and all day each weekend. When care is needed and the member's primary care physician is unavailable, members can contact Urgent Care directly to obtain an appointment. This service is a critical asset for CHP's 112,000 members by offering a more cost effective and less congested setting for care than area Emergency Rooms. This service enables CHP to consistently run rates of ER utilization 20+% below typical HMO and PPO experience.

- Dermatology services were offered within Governors Square Blvd Health Center beginning in October 2002 and were expanded in 2003 with the addition of a staff dermatologist. Wait times for dermatology appointments are declining.

3. Capital Health Plan is embarking on new and exciting innovations to further engage consumers in becoming more knowledgeable of their health care choices:

   - A secure, on-line electronic personal health record called ***CHPConnect*** is now available to all CHP members. Members are able to review:

     - A personal history of their doctor visits and procedures
     - Diagnoses
     - Current medications
     - Their children's immunizations and visit dates
     - Referrals – including start and end dates
     - Benefits including copayments for specific services
     - Prescription drug information including relative costs

   - Members have online access to accurate and reliable information about illnesses, treatment and drugs.

   - Members are encouraged to add personal information such as family history and over-the-counter medications and to populate a calendar of prevention reminders.

   - Members' treating physicians have access to this information (unless a member chooses to block that), avoiding costly duplication, improving coordination of care, management of medications and potentially offering life-saving information at the time of emergency services.

- Hospital Comparison data is currently available via a link to HealthGrades and the Florida Agency for Health Care Administration on CHP's current website.

- Members have the ability to track and monitor all services they receive through CHP.

- To enhance member engagement in the cost of potentially discretionary tests, CHP has recommended that employers add copayments to high cost diagnostic studies

While on-line access to information is not new to the insurance industry, we believe CHP is breaking new ground in the extent of information we are making available to members to engage them in managing their own care. These initiatives put Tallahassee in the forefront of transforming health care through technology – ultimately to avoid medical mistakes, reduce costs and improve care.

Capital Health
PLAN

Community Wellness Initiatives

Capital Health Plan is a local, non-profit HMO that has operated in Tallahassee and the surrounding rural communities, focusing resources and programs solely in this area since 1982. During this time Capital Health Plan has introduced extensive preventive and wellness programs which have benefited Leon County employees since 1983, the beginning of our nearly 25 year partnership.

Recognizing that poor diet and lack of exercise have dramatic health consequences that affect quality of life and drive up health care costs Capital Health Plan and a coalition of community partners attacked the obesity issue head-on with a new wellness campaign to encourage an increase in physical activity. On August 27, 2003, Capital Health Plan launched Stepping toward Health, a Community on the Move, a comprehensive wellness initiative. Mayor Marks and Commissioner Grippa provided great leadership and encouragement by entering into a walking challenge late in 2003.

The initiative helps to combat negative messages that encourage inactivity and poor diet by educating people about healthy choices and simple things they can do to move toward better health.

The Stepping Toward Health Coalition is extremely active, with exciting projects underway. CHP has now distributed more than 50,000 pedometers and more and more people are counting their steps. In addition CHP provided pedometers and collaborated with the Leon County Human Resources Department in creation of its "Walking Across Florida" initiative.

In order to ensure that health stays a community priority, the Tallahassee Wellness Council was created, a natural extension of the Stepping Toward Health Coalition. Council members are leaders in the community, including Capital Health Plan's CEO and Chief Medical Officer who will give guidance and ensure that health remains a priority with decision makers. The Tallahassee Wellness Council had its first meeting on May 4, 2004, and continues to demonstrate a great commitment to preventing disease and combating obesity.

Capital Health Plan will continue to support and promote community-wide programs to promote wellness and the engagement of individuals in taking responsibility for improving their health. Our partnership with organizations such as Leon County is a critically important foundation for this goal.

Name of Proposer: Vista Healthplan, Inc.

Executive Summary

Organization & Qualifications – An Industry Leader with Experience

Vista Healthplan Inc., (referred to hereinafter as VISTA) is an organization with corporate offices located in Tallahassee and in Broward, Miami-Dade and Palm Beach Counties. VISTA (formerly known as Healthplan Southeast in the North Florida area) has been providing quality, affordable health care since 1986. Today over 330,000 members are served through the combined North and South Florida Vista Healthplan networks, representing one of the largest managed care providers in the state. VISTA's North Florida service areas include Tallahassee, Gainesville and Pensacola. The South Florida service area is comprised of three counties; Broward, Miami-Dade, and Palm Beach.

VISTA's successful leadership team represents more than a century of industry know-how and is backed by more than 1,000 talented employees dedicated to providing customers with a level of service they want for their own families. This dynamic blend is powering the company's growth, profitability and commitment to higher standards of service for our industry.

Proposed Network – Quality and Strength in Numbers

The depth and caliber of our network of physicians are of critical importance. VISTA's South Florida HMO/POS provider network is comprised of 1,225 primary care physicians and more than 2,500 specialists. Our North Florida network has over 1,000 PCPs and specialists. Overall, more than three quarters of our physician providers are board certified. All undergo a rigorous credentialing process prior to admission to our network and are recredentialed every two years. Twenty-three hospitals in North Florida and forty-seven hospitals in the tri-county South Florida area participate with VISTA. Accessibility analysis is conducted regularly to ensure that members have convenient access to both providers and hospitals.

Plan Design –Choices to Meet Our Community's Needs

The VISTA companies offer employer groups and individuals a wide array of affordable health benefit plans and products to choose from including HMO, POS, Medicare, Medicaid, and Florida Healthy Kids. PPO, Open Access and Open Access Plus plans are

available in the South Florida service area, with expansion into North Florida currently under review. Both Open Access products encourage members to maintain a primary care physician, but offer the convenience of having direct access to our broad network of specialists, without a referral form!

Customer Service and Benefit Administration – VISTA is at Your Service

VISTA continues to make aggressive strides in fulfilling the commitment we have made to providing the level of service we want for our own families. Some recent activities to improve service and member satisfaction include:

Enhancing our web site, which provides members with easy access to information 24 hours a day, seven days a week. Members can look up benefits and copays, find participating physicians, hospitals, and pharmacies, look up Rx drug benefits and Explanation of Benefits for claims paid, request an ID card, and change primary care physicians. New capabilities are continually being added to the site.

Redesign of customer service call handling, which has dramatically improved the timeliness and accuracy of response as well as improve the first-call resolution rate.

Improving provider satisfaction by offering an internet site that allows providers to check member eligibility and status of claims on-line. A recently administered provider satisfaction survey indicated a 32% increase in satisfaction with the accuracy of claims payment, a 23% increase in satisfaction with the timeliness of claims payment, and a 26% increase in satisfaction with VISTA's ability to resolve claims problems.

Cost Effectiveness – Affordable Choices

VISTA offers a broad range of competitively priced managed health care products custom-designed to meet the needs of Leon County employees and their families. Leon County will benefit from VISTA's cost savings generated by our aggressive provider contracts and sophisticated medical and disease management programs.

We offer value-added benefits to supplement the plan designs we are quoting. VISTA has partnered with a network of fitness centers that offer discounted membership fees to promote the importance of physical fitness. VISTA also offers a complementary alternative medicine program. This benefit supplements traditional medical treatment with a network of accupunturists, massage therapists, and dieticians at a discounted rate.

Financial Performance – Strategic Growth & Profitability

VISTA's financial ratings have improved over the course of the last three years as a result of the integration of the VISTA affiliates and the management team's experience, enhancing company-wide performance. VISTA's liquidity ratios fall within industry averages, indicating that VISTA has enough current assets, without respect to liquidity, to service current liabilities as they become due. VISTA's debt/net worth ratios are significantly higher than the industry average. VISTA remains in good standing with the Florida Financial Service Commission (FSC) and has demonstrated continual financial improvement quarter after quarter. We anticipate continued growth and profitability in both the short and long term outlook.

Our Vision and Values

VISTA will be the health benefits company of choice, committed to providing the level of service we want for our own families. We value our members, providers, employees and the community at large. We are committed to treating each with:

- Respect
- Dignity
- Honesty
- Integrity
- Fairness
- Service Excellence

For value, service and competitively priced health benefits, VISTA is the right choice for Leon County employees and their families.

UNITEDHEALTH GROUP - CORPORATE

UnitedHealth Group Incorporated is a publicly held company whose common stock is traded on the New York Stock Exchange as UNH. As of March 15, 2004, UnitedHealth Group had approximately 13,483 shareholders of record and approximately 619 million shares issued and outstanding and no preferred shares issued and outstanding. No shareholder known to the company owns beneficially more than 10 percent of the outstanding shares of the Company common stock as of March 15, 2004.

From its beginnings, UnitedHealth Group has been a different kind of enterprise – entrepreneurial in spirit, principled in thinking, and innovative in action. We measure success by our progressive contributions to improving the health and well-being of the people we serve. Our success in serving the needs of people is reflected in the outstanding growth and financial performance of our company. Our long-term strategic intent is to build UnitedHealth Group into the preeminent leader in the health and well-being marketplace. We define the health and well-being marketplace as the physical, behavioral, and social health and wellness needs of individuals. In its broadest sense, it encompasses the total set of products and services that lead individual consumers to improved health and happiness.

Beginning in 1974, when group-model HMOs were the norm, UnitedHealth Group was the first company to demonstrate that the Individual Practice Association (IPA) HMO could be successful. We created the system and the standard for IPA organizations, together with the medical management and information systems to support them.

Today, UnitedHealth Group is a national leader in the consumer health services market, serving purchasers, consumers, benefit managers and providers of health care. UnitedHealth Group, through its affiliates, offers a broad continuum of health care products and services, including HMOs, point-of-service plans (POS), PPOs and health insurance products, as well managed behavioral health services, and disability management services, specialized physician and other health care professionals' networks, employee assistance services, Medicare programs, managed Medicaid services, managed pharmacy, health care evaluation services, information systems, and administrative services.

In 1999, UnitedHealth Group reorganized its corporate enterprise into six primary operating businesses, each serving a unique market. Whenever possible, our businesses work together to provide customers with an integrated set of health and well-being products and services. These businesses include:

UNITEDHEALTHCARE

UnitedHealthcare designs and operates health benefits systems with commercial, Medicare, and Medicaid products. Today, this group serves over 8.5 million individual consumers. Through its family of companies, UnitedHealth Group provides coverage for over 18 million individuals in its health service systems. On behalf of these individuals, the group arranges access to care with 430,000 physicians and other health care professionals and 3,800 hospitals nationwide and several international markets.

UNIPRISE

Uniprise provides employee solutions for large organizations with 5,000 or more employees, including benefits design and implementation, large volume transaction processing, and customer service.

OVATIONS

Ovations, through its affiliates, serves the health and well-being needs of older Americans – the country's fastest-growing demographic community. Services include underwriting and support of AARP Health Care Options, the group insurance program of the American Association of Retired Persons (AARP), and EverCare®, which contracts with physicians and other health care professionals to deliver medical care to frail, elderly residents of nursing homes. Ovations is devoted to serving the unique lifestyle needs of people ages 50 and older.

SPECIALIZED CARE SERVICES

Specialized Care Services is a portfolio of companies offering highly specialized benefits, networks, services, and resources to improve health and well-being. The companies include A.C.N. Group, Dental Benefit Providers, National Benefit Resources, Optum, Spectera, United Behavioral Health, and United Resource Networks.

INGENIX

Ingenix brings all of UnitedHealth's knowledge and information capabilities to bear in one business focus. This business serves the data analysis, consulting, research, and information services needs of all constituencies of the health and well-being marketplace, including industry, government, providers, employers, and payers.

AMERICHOICE

AmeriChoice health plans serve more than one million Medicaid, Child Health Insurance Program (CHIP) and Medicare beneficiaries in more than a dozen states from coast to coast. AmeriChoice's information technology subsidiary, Information Network Corporation (INC), is an application service provider that processes medical and dental claims, as well as maintaining customer and physician databases. It also offers a variety of other health care business solutions for AmeriChoice and other companies throughout the United States.

UNITEDHEALTHCARE – FLORIDA

UnitedHealthcare of Florida is divided into three regions across the state. The South Florida region services Palm Beach, Broward and Dade counties. The North/Central region includes the major metropolitan areas of Orlando, Daytona Beach, Ocala, Gainesville and Jacksonville. The Florida Gulf Coast region covers the West Coast of Florida including Naples, Tampa, Lakeland, Tallahassee and Pensacola. UnitedHealthcare serves over 2,000,000 members across the state in all lines of products. In recent years there has been significant network expansion throughout the state, most recently in the Tallahassee / Leon County area. The service area filing in this area was approved in October of 2004 and there are close to 10,000 members accessing our networks to date in this area. This has been an exciting expansion for UnitedHealthcare as it establishes a market presence in all major areas of the state.

Five Year Local Trend Analysis of CHP Premium Rates for Leon County, City Of Tallahassee, School Board and State of Florida

Year	Leon County	% Inc	City of Tallahassee	% Inc	Leon County School Board	% inc	State of Florida	% inc
2000	$523.90		$517.46		$620.06		$507.80	
2001	$590.30	13%	$578.04	12%	$680.28	10%	$507.80	0
2002	$679.90	15%	$707.42	22%	$780.36	15%	$583.96	15%
2003	$795.30	17%	$808.70	14%	$925.20	19%	$659.86	13%
2004	$906.40	14%	$884.84	9%	$1,036.55	12%	$766.26	16%
Average		14%		14%		15%		11%

Five-Year Retiree Rates for Family Coverage/both have Medicare

Year	CHP Premium Rates Retirees Family/Both have Medicare	% Increase
2000	512.00	
2001	563.20	10%
2002	675.30	20%
2003	749.20	11%
2004	882.40	18%
2005	908.70	3%
Average		12%

112.08 Group insurance for public officers, employees, and certain volunteers; physical examinations.--

(1) As used in this section, the term "local governmental unit" means any county, municipality, community college district, school board, or special district or any county officer listed in s. 1(d), Art. VIII of the State Constitution.

(2)(a) Notwithstanding any general law or special act to the contrary, every local governmental unit is authorized to provide and pay out of its available funds for all or part of the premium for life, health, accident, hospitalization, legal expense, or annuity insurance, or all or any kinds of such insurance, for the officers and employees of the local governmental unit and for health, accident, hospitalization, and legal expense insurance for the dependents of such officers and employees upon a group insurance plan and, to that end, to enter into contracts with insurance companies or professional administrators to provide such insurance. **Before entering any contract for insurance, the local governmental unit shall advertise for competitive bids; and such contract shall be let upon the basis of such bids.** If a contracting health insurance provider becomes financially impaired as determined by the Office of Insurance Regulation of the Financial Services Commission or otherwise fails or refuses to provide the contracted-for coverage or coverages, the local government may purchase insurance, enter into risk management programs, or contract with third-party administrators and may make such acquisitions by advertising for competitive bids or by direct negotiations and contract. The local governmental unit may undertake simultaneous negotiations with those companies which have submitted reasonable and timely bids and are found by the local governmental unit to be fully qualified and capable of meeting all servicing requirements. **Each local governmental unit may self-insure any plan for health, accident, and hospitalization coverage or enter into a risk management consortium to provide such coverage, subject to approval based on actuarial soundness by the Office of Insurance Regulation; and each shall contract with an insurance company or professional administrator qualified and approved by the office to administer such a plan.**

(b) In order to obtain approval from the Office of Insurance Regulation of any self-insured plan for health, accident, and hospitalization coverage, each local governmental unit or consortium shall submit its plan along with a certification as to the actuarial soundness of the plan, which certification is prepared by an actuary who is a member of the Society of Actuaries or the American Academy of Actuaries. The Office of Insurance Regulation shall not approve the plan unless it determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined according to generally accepted actuarial principles. After implementation of an approved plan, each local governmental unit or consortium shall annually submit to the Office of Insurance Regulation a report which includes a statement prepared by an actuary who is a member of the Society of Actuaries or the American Academy of Actuaries as to the actuarial soundness of the plan. The report is due 90 days after the close of the fiscal year of the plan. The report shall consist of, but is not limited to:

1. The adequacy of contribution rates in meeting the level of benefits provided and the

changes, if any, needed in the contribution rates to achieve or preserve a level of funding deemed adequate to enable payment of the benefit amounts provided under the plan and a valuation of present assets, based on statement value, and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities.

2. A plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities.

3. A description and explanation of actuarial assumptions.

4. A schedule illustrating the amortization of any unfunded liabilities.

5. A comparative review illustrating the level of funds available to the plan from rates, investment income, and other sources realized over the period covered by the report with the assumptions used.

6. A statement by the actuary that the report is complete and accurate and that in the actuary's opinion the techniques and assumptions used are reasonable and meet the requirements and intent of this subsection.

7. Other factors or statements as required by the [1]Department of Insurance in order to determine the actuarial soundness of the plan.

All assumptions used in the report shall be based on recognized actuarial principles acceptable to the Office of Insurance Regulation. The office shall review the report and shall notify the administrator of the plan and each entity participating in the plan, as identified by the administrator, of any actuarial deficiencies. Each local governmental unit is responsible for payment of valid claims of its employees that are not paid within 60 days after receipt by the plan administrator or consortium.

(c) Every local governmental unit is authorized to expend funds for preemployment physical examinations and postemployment physical examinations.

(3) Each local governmental unit is authorized to commingle in a common fund, plan, or program all payments for life, health, accident, hospitalization, or annuity insurance or all or any kinds of such insurance whether paid by the local governmental unit, officer or employee, or otherwise. The local governmental unit may determine the portion of the cost, if any, of such fund, plan, or program to be paid by officers or employees of the local governmental unit and fix the amounts to be paid by each such officer or employee as will best serve the public interest.

(4)(a) A local governmental unit may, at its discretion, provide group insurance consistent with the provisions of this section for volunteer or auxiliary firefighters, volunteer or auxiliary law enforcement agents, or volunteer or auxiliary ambulance or emergency service personnel within its jurisdiction. No insurance provided to volunteer personnel shall be used in the computation of workers' compensation benefits or in the determination of employee status for the purposes of collective bargaining.

(b) Benefits provided under group insurance policies pursuant to paragraph (a) shall not exceed benefits provided to employees under subsection (2) and ss. 112.19 and 112.191.

(5) The Department of Management Services shall initiate and supervise a group insurance program providing death and disability benefits for active members of the Florida Highway Patrol Auxiliary, with coverage beginning July 1, 1978, and purchased from state funds appropriated for that purpose. The Department of Management Services, in cooperation with the Office of Insurance Regulation, shall prepare specifications necessary to implement the program, and the Department of Management Services shall receive bids and award the contract in accordance with general law.

(6) The Financial Services Commission is authorized to adopt rules to carry out the provisions of this section as they pertain to its duties.

(7) All medical records and medical claims records in the custody of a unit of county or municipal government relating to county or municipal employees, former county or municipal employees, or eligible dependents of such employees enrolled in a county or municipal group insurance plan or self-insurance plan shall be kept confidential and are exempt from the provisions of s. 119.07(1). Such records shall not be furnished to any person other than the employee or the employee's legal representative, except upon written authorization of the employee, but may be furnished in any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the employee or the employee's legal representative by the party seeking such records.

(8) Patient medical records and medical claims records of water management district employees, former employees, and eligible dependents in the custody or control of the water management district under its group insurance plan established pursuant to s. 373.605 are confidential and exempt from s. 119.07(1). Such records shall not be furnished to any person other than the employee or the employee's legal representative, except upon written authorization of the employee, but may be furnished in any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the employee or the employee's legal representative by the party seeking such records.

History.--s. 1, ch. 20852, 1941; s. 1, ch. 69-300; s. 1, ch. 72-338; s. 1, ch. 76-208; s. 1, ch. 77-89; s. 50, ch. 79-40; s. 1, ch. 79-337; s. 67, ch. 79-400; s. 3, ch. 83-292; ss. 1, 2, ch. 84-307; s. 4, ch. 86-180; s. 26, ch. 90-360; s. 41, ch. 92-279; s. 55, ch. 92-326; s. 687, ch. 95-147; s. 33, ch. 96-406; s. 1, ch. 2001-123; s. 124, ch. 2003-261; s. 6, ch. 2004-305.

[1]**Note.**--Duties of the Department of Insurance were transferred to the Department of Financial Services or the Financial Services Commission by ch. 2002-404, and s. 20.13, creating the Department of Insurance, was repealed by s. 3, ch. 2003-1.

112.0801 Group insurance; participation by retired employees.--Any state agency, county, municipality, special district, community college, or district school board which provides life, health, accident, hospitalization, or annuity insurance, or all of any kinds of such insurance, for its officers and employees and their dependents upon a group insurance plan or self-insurance plan shall allow all former personnel who have retired prior to October 1, 1987, as well as those who retire on or after such date, and their eligible dependents, the option of continuing to participate in such group insurance plan or self-insurance plan. Retirees and their eligible dependents shall be offered the same health and hospitalization insurance coverage as is offered to active employees at a premium cost of no more than the premium cost applicable to active employees. For the retired employees and their eligible dependents, the cost of any such continued participation in any type of plan or any of the cost thereof may be paid by the employer or by the retired employees. To determine health and hospitalization plan costs, the employer shall commingle the claims experience of the retiree group with the claims experience of the active employees; and, for other types of coverage, the employer may commingle the claims experience of the retiree group with the claims experience of active employees. Retirees covered under Medicare may be experience-rated separately from the retirees not covered by Medicare and from active employees, provided that the total premium does not exceed that of the active group and coverage is basically the same as for the active group.

History.--s. 2, ch. 76-151; s. 1, ch. 79-88; s. 1, ch. 80-304; s. 5, ch. 81-103; s. 1, ch. 83-294; s. 1, ch. 87-373.

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LONG TERM CARE INSURANCE
DENTAL INSURANCE PLANS

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Principal Financial Group
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Group Health Insurance Plan Definitions

This section will help you understand the basics of managed care plans. Keep in mind that health insurance policies vary widely, and the information presented here is simply a guideline. Make sure you understand exactly what's included in your policy before signing the contract.

Overview of Coverage

Health insurance policies typically cover the treatment of illness, disease, and accidents, including doctor's office visits, prescriptions, diagnostics (e.g. x-rays, blood tests), hospitalization, surgery, and emergency services. Maternity care is also covered by most policies. Preventive care may or may not be covered in a basic policy, depending on the type of plan.

Optional plan provisions can often be added to the policy, such as coverage for routine vision and dental care, mental health care, or chiropractor services.

Most policies do not cover elective cosmetic surgery, experimental procedures, or work-related injuries covered by workers' compensation insurance.

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HMO

An HMO (Health Maintenance Organization) is a type of managed care plan that typically works in the following manner:

- The HMO consists of a network of "capitated" health care providers, which means these providers receive set monthly payments for each plan member (such as your employees), regardless of how frequently their services are used.
- Your employees are required to choose a Primary Care Physician (PCP) to perform many of their health care services and refer them to specialists when necessary. They are only referred to specialists within the HMO's network, except in special circumstances.
- Your employees are only responsible for a small co-payment (e.g. $10) for visits to their PCP or specialists to whom they've been referred. In most cases, no deductible is required.
- If your employees visit another physician without a referral from their PCP, they won't receive any coverage, except in certain emergencies.

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POS

In general, POS (Point of Service) plans have similar rules to HMOs, though they tend to be more flexible in offering referrals outside of the network and providing some coverage for

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self-referrals. Thus, if your employees visit their Primary Care Provider (PCP) and receive referrals to specialists when necessary, their costs and coverage are likely to be similar to an HMO. However, if they refer themselves to a specialist or doctor outside of the plan's network, they may need to pay a deductible and coinsurance (a portion of the medical fees).

Example: Under a POS plan, your employees may only be responsible for a $20 co-payment if they visit their PCP or a referred specialist inside or outside of the network. However, they may be responsible for a deductible and 20% coinsurance if they refer themselves to a network physician or 30% coinsurance if they visit an out-of-network physician.

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PPO

PPOs (Preferred Provider Organizations) typically consist of a network of providers that have agreed to provide services to plan members at discounted rates. These are generally considered the most flexible managed care plans because they usually don't require members to choose a Primary Care Physician (PCP). This means your employees receive the same coverage for any provider within the network, including specialists. They can also choose a provider outside of the network and receive coverage, though the out-of-pocket expenses will likely be higher, as demonstrated below.

Example: Under a PPO plan, your employees may be responsible for 20% coinsurance (based on discounted rates) and $150 deductible if they visit any physician within the network, or 30% coinsurance (based on non-discounted rates) and $300 deductible if they visit a physician who is not in the network.

Comparison Table, HMO, POS, and PPO

The table below compares the three types of insurance discussed in this section on several important and distinguishing features. However, it should be noted that the lines between these plans have begun to blur in recent years. For example, your provider may offer an HMO plan with fewer restrictions, so that it resembles a POS plan. This table is simply meant to be a guideline of the features generally considered typical for each type of plan.

	HMO	POS	PPO
Choice of Health Care Providers	Typically more restrictive than other plans, with no coverage for out-of-network providers or specialists seen without referral from primary care physician.	Financial incentives to use primary care physician and get referrals to other network providers.	Financial incentives to use network providers. Usually no primary care physician needs to be selected
Preventive Care	Typically covered.	Typically covered.	Sometimes covered.
Prescriptions	Typically covered.	Typically covered.	Sometimes covered. Often available as coverage for a higher premium.
Out-of-Pocket Expenses	Typically lower than other plans, but no coverage for out-of-network providers or providers seen without a referral.	Mid-range. More expensive when an out-of-network or self-referred network provider is used.	Typically higher than HMO or POS, but lower than traditional fee-for-service plans. More expensive when an out-of-network provider is used.
Premiums	Typically lower than other plans.	Typically higher than HMO plans.	Typically higher than HMO or POS, but lower than traditional fee-for-service plans.
Paperwork	Relatively insignificant.	May be more significant when an out-of-network	May be more significant when an

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or self-referred network provider is used.

out-of-network provider is used.

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Site Map

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713-626-2838 | Toll Free 888-626-6858 | Fax 713-626-1817 | Toll Free Fax 888-626-1817 | info@hcitexas.com

Self-Insured Health Plan

Leon County currently is under a fully insured HMO plan. Self-insurance or self-funding is an alternative risk transfer strategy used by employers across the country to help fund their group health care liabilities. Self-insurance has become an increasingly attractive option for many employers due to the rising costs associated with fully insured health care plans. In most cases, employers that operate self-insured health care plans, utilize various service providers to assist them in the set up and operation of their plans. A self-insured group health plan is one in which the employer assumes 100% of the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each out of pocket expense as they are incurred instead off paying a fixed premium to an insurance carrier, which is known as a fully insured plan. Typically, a self insured employer will set up a special trust fund to earmark money (employer and employee contributions) to pay incurred claims.

There are several reasons and advantages for employers to choose the self-insurance options as follows:

1. The employer can control and customize the design of the plan to meet the specific health care needs of its workforce, as opposed to purchasing a "one-size-fits-all" insurance policy.
2. The employer maintains control over the health plan reserves, enabling maximization of interest income. This income would otherwise be generated by the insurance carrier through investment of premium dollars.
3. The employer does not have to pre-pay for coverage, thereby providing for improved cash flow.
4. The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees.
5. The employer can either administer claims in-house or subcontract this service to a third party administrator (TPA). TPA's can also help employers set up their self-insured group health plans and coordinate stop-loss insurance coverage, provider network contracts and utilization review services.
6. The employer retains any savings generated by the self-insured health plan, not the insurance carrier.

The disadvantages of establishing a self-insurance health plan are as follows:

1. The employer will experience start-up costs associated with the plan design and setting up the plan administration.
2. The employer will have to dedicate more of management and staff time to the review and administer a self-insured plan, than is usually required to monitor purchased coverage.
3. The employer may experience a poor loss experience which cannot be offset by the better experience of other organizations within a group.
4. The risk factor keeps many employers from pursuing self-insured health plans. In some instances, employers have not been able to secure stop-loss insurance to cover

catastrophic claims or the stop-loss insurance becomes too expensive to support the continuation of a self-insured program.

If the County is going to consider self insurance, it must be understood that there is greater risk in self-insurance. A single catastrophic occurrence, such as a life altering illness or serious disabling accident, can substantially increase the plan's cost and potentially endanger the County's financial health. As a hedge against this possibility, self-insurers can opt for re-insurance coverage, also referred to as Stop-Loss coverage. For a premium, this coverage takes over after a designated level of expense has been reached and protects against catastrophic loss. Employers that self-insure may choose to purchase specific stop-loss insurance with a maximum dollar limit on their liability for paying health insurance claims. Additionally, employers that self-insure may choose to purchase aggregate stop-loss insurance to cover situations in which the employer's total claims exceed a stated dollar amount within a stated period of time. Even a well functioning plan may show no savings for the first year or two because of plan design and start-up costs

Health Savings Accounts (HSA)

As an additional option to employees and not a replacement for current health plan offerings, the Board may want to consider offering a Health Savings Account. Health Savings Accounts (HSA) were recently created in Medicare legislation signed into law by President Bush. An HSA is an alternative to traditional health insurance. It is a savings product that offers a different way for employees to pay for their health care. HSA's enable employees to pay for current health expenses and future qualified medical expenses on a tax free basis.

An employee must be covered by a High Deductible Health Plan (HDHP) to be able to take advantage of HSA's. This is sometimes referred to as catastrophic coverage. This type of plan does not pay for the first several thousand dollars of health care expenses (you must meet a deductible first). A HDHP generally costs less than what traditional health coverage costs, so the money that is saved on insurance can be put into the HSA. In addition, the employer may elect to match employee contributions up to a certain dollar amount.

In order to qualify to have an HSA, the HDHP minimum deductible must be at least $1,000 for single coverage or $2,000 for family coverage. The annual out-of-pocket limit cannot exceed $5,000 for single coverage and $10,000 for family coverage. The deductible amount is indexed every year. An HSA is not something that is purchased; it is a savings account which employees can deposit money on a tax-preferred basis. The only product that is purchased is a High Deductible Health Plan.
Some features and advantages of an HSA include the following:

- HSA contributions are tax deductible
- Interest earned on the account is tax free
- Tax free withdrawals may be made for qualified medical expenses
- Unused funds and interest are carried over
- The HSA is administered by a Trustee/Custodian

Some disadvantages of an HSA include the following:

- HSA's are relatively new products and long term results have not been reviewed.
- HSA's are mainly attractive to high-wage earners and healthier employees.
- Industry experts believe this is a consumer-driven strategy to transfer more of the responsibility for health care costs to employees.
- HSA's appear to be more attractive when employees are required to pay a much higher portion of the insurance cost.

EMPLOYEE HEALTH BENEFITS

SELF-FUNDING

WHAT EVERY AAHSA CFO & HR EXECUTIVE NEEDS TO KNOW

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GOOD NEWS: SELF-FUNDED HEALTH PLANS ARE NOT JUST FOR CORPORATE GIANTS ANYMORE

If you think the benefits of self-funded health plans are reserved for companies with sizeable workforces, expertise in health benefits management, and the ability to take significant financial risks, think again.

The advantages of self-funding—***cost control, cash flow improvement, and plan design flexibility***—are available to companies with as few as 50 participants. Today, the health benefits industry and related ancillary services offer an array of resources to help smaller businesses overcome the obstacles that formerly made it difficult for them to self-fund. For example:

- Stop-loss carriers are becoming adept at working with smaller companies to mitigate financial risk.
- Today's Third Party Administrators (TPAs) provide a broad range of services to supplement the human resource capabilities of small and mid-sized companies.
- Experienced health plan consultants help companies design plans to meet the needs of diverse workforces.

These resources put the benefits of self-funding within the reach of companies of all sizes and financial circumstances.

What is a self-funded health plan?

A health plan under which an employer assumes the responsibility and related financial risk for paying plan participants' health care expenses is known as a **self-funded health plan**.

Stop-loss coverage is often purchased to protect self-funded companies from high claims by putting a ceiling on financial risk. In contrast, under a **fully insured plan**, the employer pays fixed monthly premiums to an insurance carrier, and the carrier assumes the responsibility and related financial risk for paying plan participants' claims.

THE UNRELENTING PROBLEM: FULLY INSURED PREMIUM COSTS MOUNT AND MOUNT AND ...

Year after year, fully insured companies across the country face hefty increases in their health insurance premiums. The 2003 Employee Health Benefits survey by the Kaiser Family Foundation and Health Research and Educational Trust revealed that fully insured premiums for employer-based health benefits rose by 13.9 percent in 2003. This increase made 2003 the third consecutive year of double-digit increases, with a higher rate of growth than any year since 1990.

Small Companies Hit Hardest by Premium Cost Increases

	Conventional	HMO	PPO	POS	All Plans
Firm Size					
Small Firms (3-199 Workers)	19.9%	14.3%	15.4%	15.6%	15.5%
Large Firms (200+ Workers)	10.4%	15.6%	12.8%	11.8%	13.2%
All Firm Sizes	**14.3%**	**15.2%**	**13.7%**	**13.2%**	**13.9%**

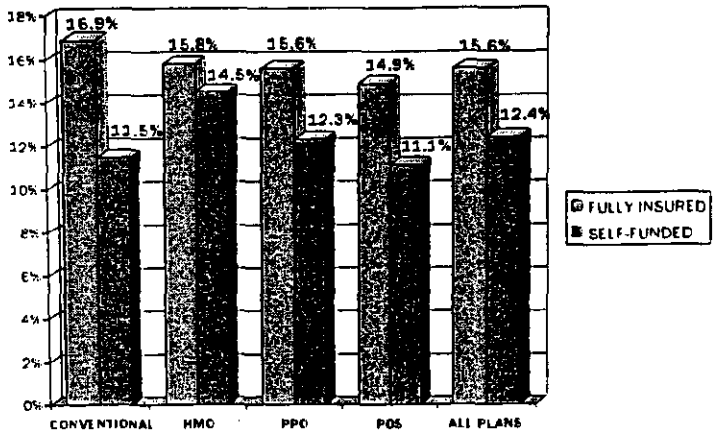
Small, fully insured companies experienced a 15.5 percent premium cost increase, while premium costs of larger companies increased by a lesser 13.2 percent.

The survey also showed that in 2003, fully insured premium increases exceeded the overall inflation rate by nearly 12 percent. Moreover, premiums for fully insured plans are rising at a much higher rate (15.6 percent) than premium equivalents for self-funded plans (12.4 percent). (Increases in premium equivalents are a proxy measure of the growth in underlying medical claims.)

This is not news. As the Kaiser survey shows, premium increases for fully insured plans have outpaced premium equivalent increases for self-funded plans for many years.

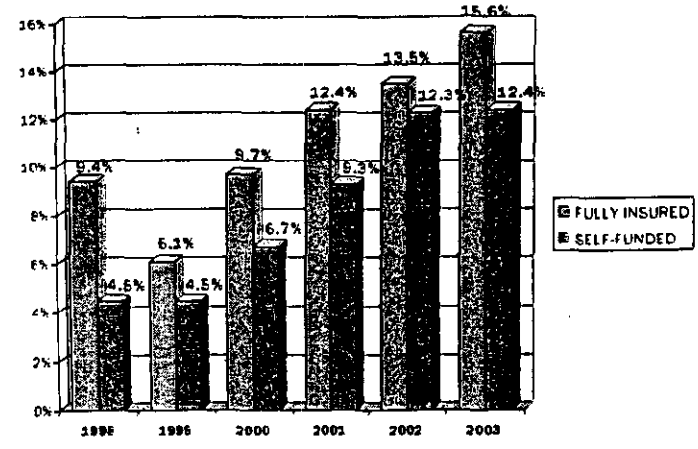
Premiums for fully insured plans rose by 15.6% in 2003, while self-funded plan premium equivalents rose by 12.4%.

Premium Increases, by Plan Type and Funding Arrangement, 2003



Premium increases for fully insured plans have historically outpaced self-funded plan premium equivalent increases.

Premium Increases, by Funding Arrangement, 1998-2003



NOTE: Data on premium increases reflect the cost of health insurance premiums for a family of four.

MORE COSTS, LESS CONTROL FOR FULLY INSURED COMPANIES

If the Kaiser survey data is not sufficiently discouraging to fully insured companies, consider the enormous frustration that fully insured companies experience when they see their employees' annual health claims fall below the total cost of premiums.

It is important to remember that small and mid-sized companies that fully insure often are community-rated—that is, their rates depend not on their specific claims experience but on the claims of other companies in their geographic region. Even if a company's claims experience is good and falls below the total cost of premiums, the company still may receive the same rate increases as other companies in its area.

The Employee Retirement Income and Security Act of 1974 (ERISA) exempts self-insured plans from state regulation, including reserve requirements, mandated benefits, premium taxes, and consumer protection regulations.[3]

Also remember that fully insured companies bear additional costs in the form of up-front administrative expenses charged by their insurers. Typically, these charges add another 10 percent to a company's total health benefits expenses.[4] While it is true that self-funded companies have their own administrative expenses to pay, self-funded companies are able to exert controls that can increase administrative efficiency and effectiveness, resulting in lower administrative costs.

SMALLER COMPANIES MORE APT TO FULLY INSURE

But who are the fully insured? Certainly not the corporate giants. Large companies with ample financial resources and internal expertise in benefits administration are commonly considered ideal candidates for self-funding. Conversely, small and mid-sized companies with less extensive resources are more likely to take the fully insured route. At least in part, these companies have been influenced by consultants, whose lack of comprehensive, up-to-date knowledge of the evolving mechanics of self-funding leads them wrongly to conclude that self-funded plans are ill-advised for small and mid-sized businesses.

GROWTH IN SELF-FUNDING PREDICTED FOR SMALL AND MID-SIZED COMPANIES

Fortunately, there are many who know better. Consequently, the appeal of self-funding is rapidly expanding among small and mid-sized businesses. "Self-funding has grown many thousand percent in the past 15 years ... and most of that growth has been among small and very small employers," said Frederick Hunt, Jr., President of the Society of Professional Benefit Administrators. Hunt attributes this growth in part to the different attitudes of insurance companies toward large and small businesses. According to Hunt, large companies looking to fully insure "can exercise the clout of their size to demand special rates and flexibility from insurers [while] small employers tend to get inflexibility at higher prices (or no insurance offered at all)."

Hunt concludes: As small companies with fully insured health plans realize that they can "safely custom design a plan for the needs of their particular workers ... and save as much as 40 percent on the overall cost," the choice to self fund becomes clear.[6]

And in a December 2003 article, *The Wall Street Journal* quotes Roger Edgren, consultant with Marsh & McLennan Co.: "We are definitely seeing a trend in companies looking at self-insurance." Edgren, too, predicts growth among small and mid-sized companies opting for self-funding in the coming years.[7]

SELF-FUNDING OFFERS BIG ADVANTAGES TO COMPANIES LARGE AND SMALL

Small and mid-sized companies gain the same advantages as their larger counterparts when they implement self-funded health care plans:

- Financial and administrative control.
- Improved cash flow.
- Plan flexibility.

Financial and administrative control.
Administration of a health plan is an invisible process to a company whose health plan is fully insured. Each month, the company pays a premium, which includes charges for administration of the plan as well as reasonably expected claims, and the insurer performs all administrative tasks—outside the company's vision or control.

Advantages of self-funding

- Financial and administrative control.
- Improved cash flow.
- Plan flexibility.

When a company makes the change to self-funding, it assumes responsibility for administration of the health plan. With this responsibility comes the ability to:

- Operate efficiently and effectively.
- Detect areas where modification of systems and processes may be desirable or necessary.
- Make continual improvement in plan operations, with a goal of optimizing plan performance, improving employee satisfaction and, ultimately, saving money.

Improved cash flow.
Companies that self-fund their health plans receive significant cash flow advantages. These advantages are:

1. **Pay as you go.** Under a fully insured health plan, a company pays premiums to pre-fund claims and other costs. The insurer uses these pre-paid funds to pay plan participants' claims. In addition, the insurer retains a portion of the premiums to cover overhead costs and to compensate itself for the services it performs and the financial risk it assumes.

   A company with a self-funded plan does not pre-fund its claims costs. Rather, the company pays claims as they are incurred.[8] This allows the company, not the insurer, to invest and receive returns on unused claims funds. Of course, many small companies use TPAs for claims administration and plan management; however, TPA charges typically are lower than those of traditional insurers.

2. **Claims liability.** At the end of a plan year in which claims have been lower than anticipated, a traditional insurer keeps the premiums, and no savings are returned to the fully insured company. When claims paid by a company's self-funded plan are lower than anticipated, the savings belong to the company alone.

3. **Premium taxes.** Self-funded health insurance plans are liable for state taxes only on stop-loss premiums. Conversely, fully insured plans are liable for state premium taxes on total plan cost. According to industry experts, this disparity results in direct, automatic savings to a company that self-insures. These savings are estimated to be two to three percent of the premiums' dollar value.[9]

   The cash flow bottom line: all cost savings resulting from the above advantages can be invested, producing a positive return on investment for the company that self-funds its health plan.[10]

Plan flexibility.

Traditional insurers offer "one-size-fits-all" health plans. As a result, a company with a fully insured health plan may be forced to pay for benefits its employees will not utilize. In addition, the company may be unable to offer other benefits its employees particularly need.

The flexibility of self-funding allows a company to custom-design a cost-effective health plan tailored to employees' specific needs. For instance, high-cost benefits that employees do not value can be eliminated, replaced by benefits that employees particularly want—often for a lower cost.

With the help of experienced plan design specialists, a company can identify additional cost-saving opportunities while custom building a plan that supports corporate objectives and offers a range of options matching the needs of a diverse workforce. For example, a company may—

- Develop a more cost-effective plan by excluding or limiting benefits, while still meeting employees' needs.
- Implement a care management program to direct participants toward the most efficacious and cost-effective medical care.
- Offer new alternative health plan options, such as consumer-driven health plans.
- Provide coverage for alternative treatment procedures, such as chiropractic services and acupuncture.
- Design prescription drug plans that provide cost-saving opportunities.

The flexibility of self-funded health plans offers another important advantage to companies with multiple locations. Because self-funded plans are not bound by state law requirements, a multi-location company is not burdened with managing multi-state plans. Instead, the company can design and manage a single self-funded plan that fits the needs of employees in diverse locations.

CHALLENGES OF SELF-FUNDING

When small and mid-sized companies explore the potential benefits of self-funding, they may encounter challenges not faced by larger corporations. For instance, small and mid-sized companies may—

- Lack internal resources (e.g., personnel and specialized expertise) to manage and administer self-funded plans.
- Experience large cost fluctuations due to the unpredictability of the timing of claims.
- Be wary of taking on the financial risk inherent in self-funding.

Fortunately, these challenges can be met through accurate claims administration, appropriate risk management strategies, and effective plan design.

Claims administration and plan management.
Frequently, a small or mid-sized company's self-funded health plan is managed and administered by a TPA. Third party administration is not a new industry. Since the inception of self-funded health plans, TPAs have provided services such as claims administration and eligibility management.

Services offered by TPAs to administer self-funded plans include:

- Managing plan eligibility and enrollment.
- Issuing identification cards.
- Conducting enrollment meetings.
- Providing employee education.
- Responding to plan participants' questions and resolving issues.
- Negotiating, obtaining, and renewing stop-loss coverage.
- Managing and monitoring stop-loss administration.
- Providing (or contracting with vendors to provide) case management, disease management, pharmacy benefit management, and provider network management.
- Negotiating provider discounts.

There is some evidence that the financial risk associated with self-funding for small companies may actually be lower than the risk associated with self-funding for larger companies. For example, self-funded health plans with 200 employees have a 14 percent probability that actual claims will exceed projected claims. This risk increases to 26 percent for companies with 1,000 employees. The reason? The larger the number of employees in a group, the larger the chance that a member or members of the group will incur catastrophic health care costs.[7]

Alleviating risk through strategic plan design.
As discussed earlier, self-funded plans have a great deal of flexibility when it comes to plan design. As a result, companies that self-fund can custom-design their health plans to drastically reduce risk. Effective strategies to reduce risk include excluding or limiting certain benefits and implementing strong care, disease, and pharmacy management programs.

Alleviating risk through stop-loss coverage.
Stop-loss coverage protects self-funded companies from high claims by putting a ceiling on financial risk. Practically speaking, stop-loss coverage changes a fully self-funded plan into a partially self-funded plan that still offers the same cost control opportunities.

There are two types of stop-loss coverage: specific and aggregate.

While it may be easier for large companies to obtain stop-loss insurance, "the stop-loss industry has matured and become more and more adept at tailoring services for small plans."

- **Specific stop-loss coverage** protects a company against claims above a specified amount on a per-participant or per-family basis. An experienced consultant can work with a company to set the amount at a level that reflects the company's risk tolerance.

- **Aggregate stop-loss coverage** protects a company against accumulated claims that exceed a specified ceiling. The stop-loss insurer is responsible for any claims above this ceiling.

Aggregate stop-loss coverage generally is provided on an annual basis; however, it also can help protect a company from interim cash flow problems that arise when monthly claims fluctuate above projections. The difference is made up as claims in other months fluctuate below projections. At year-end, an annual reconciliation is performed. At that time, an adjustment can be made if overall claims for the year were higher or lower than projected.

How much stop-loss coverage does a company need, and how much will the coverage cost? The answers to these questions depend on a number of interrelated factors. These factors include the company's assessed level of risk, the size of its workforce, and the amount of risk it is willing and able to assume. The majority of companies that self-fund typically obtain both specific and aggregate stop-loss coverage.

Is Self-Funding a Good Fit?

This question should be explored with the help of a specialist in health plan design. Factors to be considered in evaluating whether a self-funded plan meets a specific company's objectives and fulfills the needs of its employees include the following:

- Current and projected future health care cost trends.
- The company's health care claims history.
- The company's projected future claims.
- Makeup of the company's workforce.
- The projected cost of plan management and administration.
- Availability of stop-loss coverage.
- Financial risk tolerance.

An experienced plan design specialist also can help a company explore the potential benefits of developing a health benefits program with multiple plan options, including consumer-driven health plans and traditional PPO plans, and assist in obtaining stop-loss coverage.

SELF-FUNDING AS A LONG-TERM SOLUTION

Small and mid-sized companies across the country continue to bear the brunt of rising health care costs—with no end in sight. For these companies, self-funding may be a lifeline, connecting them to valuable opportunities for increased cost control and improved cash flow. And the flexibility of self-funding allows for the development of comprehensive health benefit programs with options matching the needs of employees from diverse backgrounds and lifestyles.

ABOUT BEACON HEALTH BENEFIT SOLUTIONS

Beacon Benefit Communicators (BBC), endorsed by several State Associations including NYAHSA, is pleased to announce the expansion of their services to include Beacon Health Benefit Solutions. Designed exclusively for AAHSA members, BBC worked with AAHSA, NYAHSA and PERFORMAX to create Beacon Health Benefit Solutions–a program tailored to meet the unique health and benefits challenges our members face as non-profit organizations.

WHAT MAKES PERFORMAX DIFFERENT

PERFORMAX is a leading national employee benefits provider with offices across the country and plan participants in all 50 states. PERFORMAX designs, manages and administers employee health and benefit programs for midsize employers. PERFORMAX enables you to provide high quality benefits for your employees while managing your costs using flexible and customized plan solutions.

PERFORMAX offers:

- **Fully integrated, comprehensive solutions**—Using a proprietary approach to benefit plan design and management, PERFORMAX custom builds a benefit plan for you, allowing you to truly manage your companies' healthcare cost trends and deliver valuable benefits for your employees.
- **Consultation from start to finish**—PERFORMAX begins plan design with an understanding of your business, your financial objectives, and your workforce needs.
- **Control of your health plan**—PERFORMAX provides detailed plan performance reports and analyses which will bring emerging issues to the forefront, highlighting major factors driving your costs, and enable you to make informed decisions based on reliable, timely information.
- **Self-service and employee education**—PERFORMAX delivers a broad array of capabilities to simplify plan administration processes and optimize administrative efficiency. Innovative use of multimedia formats—from traditional paper communications to the Internet and beyond—eases plan administration and encourages your employees and their families to become informed consumers of their benefits.

Beacon Health Benefits Solutions is an exclusive health care program for AAHSA members that features:

- A proprietary plan design that includes the innovation of a consumer-driven health plan solution.
- Long-term cost control strategies and multiple plan options to meet employees' diverse needs.
- Maximum flexibility and control over rising health care costs.
- Customized approach to match each facility's specific HR and financial objectives.
- Administered and managed by PERFORMAX, a recognized leader of self-funded health care programs.

For additional information, visit www.GetPERFORMAX.com.

SOURCES

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[2] *Ibid.*

[3] *Ibid.*

[4] Ortner, Nickolas J., "Self-Insured Healthcare Risk-Take It or Leave It," Benefits Perspectives, Summer 2003.

[5] *Ibid.*

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[7] Windham, Chris, *The Wall Street Journal Online*, "Self-Insurance Plans Gain as Premium Costs Jump," December 30, 2003.

[8] Harker, Carlton, *Self-funding of Health Care Benefits*, International Foundation of Employee Benefit Plans, Inc., 2003, pp. 2-5.

[9] Rosenfeld, Barry, "Is a Self-Funded Health Plan Right for You?" *Employee Benefit Plan Review*, April 2003.

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Comparable Florida Counties with Self-Funded Medical Plans

COUNTY CITY	Self Insured Plans	Stop-Loss Insurance	Administrator
Brevard	yes	yes	Aetna, Health First, Cigna
Manatee	yes	no	Employer
Pinellas	yes	yes	United Health Care
Sarasota	yes	yes	Aetna, Employer Mutual
St. Johns	yes	yes	Blue Cross/Blue Shield
St. Lucie	yes	yes	EMI
Volusia	yes	yes	Brown and Brown

Comparable Florida Counties that have issued RFP's for Medical Services

COUNTIES	BID DATE	PROVIDER
ALACHUA	199	BLUE CROSS AND BLUE SHIE
CHARLOTT	200	BLUE CROSS AND BLUE SHIE
ESCAMBI	N/	BLUE CROSS AND BLUE SHIE
OSCEOL	2001/200	CIGN
PINELLAS	199	UNITED HEALTHCA
SARASOTA	199	AETNA

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Bush/Jennings
Policy and Budget Recommendation
Fiscal Year

Appropriations Bill

Governor's Recommendations 2005-06

Public Employees Relations Commission		
Commissioners	$ 86,755	$ 88,255
Commissioner - Parole and Probation	$ 86,755	$ 88,255
State Attorneys:		
Circuits with 1,000,000 Population or less	$ 138,586	$ 140,086
Circuits over 1,000,000 Population	$ 143,363	$ 144,863
Public Defenders:		
Circuits with 1,000,000 Population or less	$ 133,096	$ 134,596
Circuits over 1,000,000 Population	$ 137,684	$ 139,184

None of the officers and commission members whose salaries have been fixed in this section shall receive any supplemental salary or benefits from any county or municipality.

3. SPECIAL PAY ISSUES

Effective June, 2006, from funds in Specific Appropriations 1151, 1175, 1184, 1193, 1207, 1210, 1216, 1223, 1232 and 1238, $110,531 from General Revenue Funds and $48,611 from trust funds are provided to the Department of Law Enforcement to fund the Performance Based Compensation Plan, as developed by the department, to provide a 2 percent performance based increase for those employees who exceed performance expectations outlined in employee work plans.

From funds in Specific Appropriation 1175 and 1193, $346,500 from the General Revenue Fund and $89,760 from trust funds are provided to the Department of Law Enforcement to implement the Sworn Structured Retention and Recruitment Plan as described in the department's legislative budget request (issue code 4003A00). No payout under this plan will be made before January 2006.

4. CRITICAL CLASS ADJUSTMENTS

Effective November 1, 2005, from the funds in Specific Appropriation 2086, $5,900,000 from the General Revenue Fund and $1,900,000 from trust funds are provided for the purpose of addressing critical salary needs in certain classes experiencing excessive turnover and compression issues resulting in an inability to recruit, hire and retain qualified employees, subject to collective bargaining negotiations. Of these amounts, $4,000,000 from the General Revenue Fund and $1,500,000 from trust funds shall be allocated for unit and non-unit employees in the professional health care collective bargaining unit, and $1,900,000 in

Additionally, the employee share of the State Group Health Insurance Plan premiums and the employee share of the State-Contracted Health Maintenance Organization premiums shall continue at $48.68 per month for individual coverage and $175.14 per month for family coverage.

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C. Effective January 1, 2006, there is hereby created within the State Group Health Insurance Program a State Group Health Insurance Standard Plan, a State Group Health Insurance High Deductible Health Plan with a Health Savings Account feature, a State-Contracted Health Maintenance Organization Standard Plan, and a State-Contracted Health Maintenance Organization High Deductible Health Plan with a Health Savings Account feature.

Health Savings Accounts shall be offered to employees in association

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with the State Group Health Insurance High Deductible Health Plan and the State-Contracted Health Maintenance Organization High Deductible Health Plan, and shall be administered in accordance with the requirements and limitations of federal provisions relating to the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The State shall contribute to an employee's Health Savings Account on a dollar-per-dollar matching basis, not to exceed annual contributions totaling $500.00 for individual coverage and $1,000.00 for family coverage. An employee must contribute to a Health Savings Account on a payroll deduction basis in order to qualify for the State matching contribution. Funding for the state match is subsumed in the state premium contribution for the State Group Health Insurance High Deductible Health Plan and the State-Contracted Health Maintenance Organization High Deductible Health Plan.

D. Funds are provided in Specific Appropriation 2087, to pay the State share of the premium for the State Group Health Insurance Standard Plan, the State Group Health Insurance High Deductible Health Plan, the State-Contracted Health Maintenance Organization Standard Plan, and the State-Contracted Health Maintenance Organization High Deductible Health Plan to the executive, including the state university system, legislative and judicial branch agencies which shall increase, effective January 1, 2006.

1) The State share of the premium for the State Group Health Insurance Standard Plan, the State Group Health Insurance High Deductible Health Plan, the State-Contracted Health Maintenance Organization Standard Plan, and the State-Contracted Health Maintenance Organization High Deductible Health Plan to the executive, including the state university system, legislative and judicial branch agencies for employees participating in a pay plan class which are required to make contribution towards health insurance coverage, effective January 1, 2006, shall be $340.84 per month for individual coverage and $704.90 per month for family coverage.

2) The State share of the premium for the State Group Health Insurance Standard Plan and the State-Contracted Health Maintenance Organization Standard Plan to the executive, including the state university system, legislative and judicial branch agencies for employees participating in a pay plan class which are not required to make contribution towards health insurance coverage, including participants of the Spouse Program in accordance with s. 60P-2.0036, Florida Administrative Code, effective January 1, 2006, shall be $397.84 per month for individual coverage and $905.04 per month for family coverage.

3) The State share of the premium for the State Group Health Insurance High Deductible Health Plan and the State-Contracted Health Maintenance Organization High Deductible Health Plan to the executive, including the state university system, legislative and judicial branch agencies for employees participating in a pay plan class which are not required to make contribution towards health insurance coverage, including participants of the Spouse Program in accordance with s. 60P-2.0036, Florida Administrative Code, effective January 1, 2006, shall be $355.84 per month for individual coverage and $769.20 per month for family coverage.

4) The employee share of the premium for the State Group Health Insurance Standard Plan for employees participating in a pay plan class which are required to make contribution towards health insurance coverage, effective January 1, 2006, shall be $57.00 per month for individual coverage and $200.14 per month for family coverage.

5) The employee share of the premium for the State Group Health Insurance High Deductible Health Plan for employees participating in a pay plan class which are required to make contribution towards health

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insurance coverage, effective January 1, 2006, shall be $15.00 per month for individual coverage and $64.30 per month for family coverage.

6) The employee share of the premium for the State-Contracted Health Maintenance Organization Standard Plan and the State-Contracted Health Maintenance Organization High Deductible Health Plan with a Health Savings Account feature for employees participating in a pay plan class which are required to make contribution towards health insurance coverage, effective January 1, 2006, shall be the difference between the total negotiated monthly premium (by State-Contracted Health Maintenance Organization for individual or family coverage by Plan) and the State share of the premium as stated in subparagraph D.1.

7) An employee participating in a pay plan class which is not

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required to make contribution towards health insurance coverage, including participants of the Spouse Program in accordance with s. 60P-2.0036, Florida Administrative Code, effective January 1, 2006, will continue to be exempt from making contributions.

E. All benefits as provided in the current State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document, current Health Maintenance Organization contracts, and other such health insurance benefits as approved by the Legislature shall remain in effect for the period of July 1, 2005, through December 31, 2005. Effective January 1, 2006, all benefits as provided in the current State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document, current Health Maintenance Organization contracts, and other such health insurance benefits as approved by the Legislature shall remain in effect, except as otherwise provided by this section.

F. From the funds in Specific Appropriation 2090, $500,000 is provided to the Department of Management Services to develop and implement a state employee education and awareness campaign directed to actively advise state employees of changes to the state employee health insurance program including high deductible health insurance options with health savings accounts. The education and awareness campaign shall be implemented no later than October 1, 2005.

1) For the State Group Health Insurance Standard Plan:

In-Network Physician Office Visit Copayment - $20 Primary/ $30 Specialist
In-Network Emergency Room Visit Copayment - $75 (waived if admitted)

2) For the State Group Health Insurance High Deductible Health Plan with a Health Savings Account:

In-Network Deductible - $1,250 individual / $2,500 family
Out-of-Network Deductible - $2,500 individual/ $5,000 family
In-Network Coinsurance - 20%
Out-of-Network Coinsurance - 40%
In-Network Physician Office Visit Coinsurance - 20% Primary / 20% Specialist
Out-of-Network Physician Office Visit Coinsurance - 40% Primary/ 40% Specialist
In-Network Emergency Room Visit Coinsurance - 20%
Out-of-Network Emergency Room Visit Coinsurance - 40%
In-Network Per Hospital Per Admission Coinsurance - 20%
Out-of-Network Per Hospital Per Admission Copayment - $1,000
In-Network Out-of-Pocket Maximum - $3,000 individual / $6,000 family
Out-of-Network Out-of-Pocket Maximum - $7,500 individual / $15,000 family

Retail Coinsurance for Generic Drugs with Card - 30%
Retail Coinsurance for Preferred Brand Name Drugs with Card - 30%
Retail Coinsurance for Non-Preferred Brand Name Drugs with Card - 50%
Mail Order Coinsurance for Generic Drugs - 30%
Mail Order Coinsurance for Preferred Brand Name Drugs - 30%

3) For the State-Contracted Health Maintenance Organization Standard Plan:

In-Network Physician Office Visit Copayment - $20 Primary / $30 Specialist
In-Network Emergency Room Visit Copayment - $75 (waived if admitted)

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4) For the State-Contracted Health Maintenance Organization High Deductible Health Plan with a Health Savings Account:

In-Network Deductible - $1,250 individual / $2,500 family
In-Network Coinsurance - 20%
In-Network Physician Office Visit Coinsurance - 20% Primary / 20% Specialist
In-Network Emergency Room Visit Coinsurance - 20%
In-Network Per Hospital Per Admission Coinsurance - 20%
In-Network Out-of-Pocket Maximum - $3,000 individual / $6,000 family

Retail Coinsurance for Generic Drugs - 30%
Retail Coinsurance for Preferred Brand Name Drugs - 30%

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Retail Coinsurance for Non-Preferred Brand Name Drugs - 50%
Mail Order Coinsurance for Generic Drugs - 30%
Mail Order Coinsurance for Preferred Brand Name Drugs - 30%
Mail Order Coinsurance for Non-Preferred Brand Name Drugs - 50%

Pharmacy coinsurance is applied after the individual or family deductible has been satisfied.

G. The Department of Management Services shall maintain the preferred brand name drug list to be used in the administration of the State Employees' Prescription Drug Program.

H. Supply limits under the State Employees' Prescription Drug Program shall continue as provided in s. 110.12315, Florida Statutes.

I. The Department of Management Services shall be encouraged to explore enhancement alternatives for the State Group Health Insurance Program. These enhancements may include, but are not limited to, web-based developments such as technological solutions, automation, paperless billing, and real-time medical information reporting.

J. The Department of Management Services may contract with a Tricare Supplement vendor offering such a product on a group basis with group rates. Such benefit offering is to be considered part of the State Group Insurance Program. Enrollment is to be in lieu of the State Group Health Insurance Standard Plan, the State Group Health Insurance High Deductible Health Plan, the State-Contracted Health Maintenance Organization Standard Plan, or the State-Contracted Health Maintenance Organization High Deductible Health Plan. Eligibility and administration is to be consistent with other offerings under the State Health Insurance Program. To fund the premiums charged for the supplement, the employing agency shall contribute an amount not to exceed the contribution paid by the employing agency for other state-sponsored health insurance benefits to the State Employee Health Insurance Trust Fund. The employee shall be responsible for any premium in excess of the contribution paid by the employing agency.

K. All provisions of this section are subject to collective bargaining.

6. OTHER PROVISIONS

The state shall provide up to six (6) credit hours of tuition-free courses per term at a state university or community college to full-time employees on a space available basis as authorized by law.

All state branches, departments and agencies which have established or approved personnel policies for employees relating to the payment of accumulated and unused annual leave shall not provide payment which exceeds a maximum of 480 hours of actual payment to each employee for accumulated and unused annual leave.

Upon termination of employees in the Senior Management Service, Selected Exempt Service, or positions with comparable benefits, payment for unused annual leave credits accrued on the member's last anniversary date shall be prorated at the rate of one-twelfth (1/12) of the last annual amount credited for each month, or portion thereof, worked subsequent to the member's last anniversary date.

SECTION 9. There is hereby appropriated the sum of $163,976,926 in nonrecurring General Revenue, $221,998,235 in nonrecurring Medical Care Trust Fund and $40,035,548 in nonrecurring Grants and Donations Trust Fund to the Agency for Health Care Administration to cover Fiscal Year 2004-05 Medicaid program costs. This section shall take effect upon the General Appropriations Act becoming law.

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SECTION 10. There is hereby appropriated $3,844,010 from the Operations and Maintenance Trust Fund within the Agency for Persons with Disabilities to be used as match for funds in Specific Appropriation 2090 to expand the Family and Supported Living Waiver.

SECTION 11. There is hereby appropriated $33,462,540 from the Operations and Maintenance Trust Fund within the Agency for Persons with Disabilities to be used as match for funds in Specific Appropriation 2090 to expand the Home and Community-based Services waiver to serve persons on the waitlist.

SECTION 12. There is hereby appropriated $1,000,000 from the General Revenue Fund to the Justice Administrative Commission for Fiscal Year 2004-05 for post-conviction capital collateral cases-registry attorneys. This appropriation is for transfer to the Department of Financial

Bob Inzer

CLERK OF THE CIRCUIT AND COUNTY COURTS
LEON COUNTY ※ TALLAHASSEE, FLORIDA

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TALLAHASSEE, FLORIDA 32301

February 14, 2005

Ms. Lillian Bennett
Director of Human Resources
Leon County Board of County Commissioners
301 S. Monroe Street
Tallahassee, FL 32301

Dear Lillian:

SUBJECT: Health Care Costs When Both Spouses Work for Separate Leon County Governmental Agencies

For many years Leon County and the Clerk's Office have been offering an opt-out payment (currently $300/month) to employees who can produce documentation showing that they have health insurance coverage through a spouse in an agency other than Leon County governmental agencies (Leon County Board of Commissioners, Clerk of Courts, Property Appraiser, Tax Collector, Sheriff and Supervisor of Elections). The purpose and effect of this policy is to provide a benefit to employees who are procuring health care benefits through their spouse and to encourage those employees to shift their insurance coverage to a non-county agency. The opt-out payment saves the county money and avoids risk. The reward for doing so for the employee is a monthly payment.

In a different vein, it is the practice of the Board to pay the full amount of the health contract when both of the spouses work for the Board. However, when an employee and their spouse work for different county agencies within Leon County government, there is no similar practice.

I believe that the county and its agencies should treat each employee as an individual and provide benefits without respect to where their spouse works. I

think it is important to point out that this is the only benefit where employees are excluded from participation based upon their spouse's employer. To the best of my knowledge, we are the only employer in Leon County making this distinction. The current practice is a source of employee frustration and in my opinion indefensible.

My recommendation to the Board is that we treat each employee as individuals. Employee who can demonstrate that they have health insurance benefits through their spouse (without regard to where the spouse is employed) is entitled to the $300 opt-out benefits. I recognize that this will result in a small increase in cost to the Board or the various county agencies. However, it is the fairest way to treat our employees and it is consistent with the way other employers have implemented their opt-out plan.

If the Board is not willing to make this move, I am hopeful at a minimum that it will at least eliminate the discrimination that exists with respect to employees who work for different county agencies. These employees should at a minimum be treated no worse than if both of them were employed by the Board; namely, the total cost of their health benefits are paid by the employer.

I appreciate the opportunity to address this issue and continue to work with the Board in the development and implementation consistent employee benefits.

Sincerely,

Bob Inzer
Clerk of Circuit and County Court

BI/cam